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STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

JANUARY 1979

Lawyer-physician relationships . . . Political division of Government offers new challenge for medicine . . . CME requirements for relicensure of Wisconsin physicians . . . Hemoccult screening for colorectal neoplasms . . . Survey of blood ordering practices for 12 elective surgical procedures

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Front Page Update

Uniform claim form in demand. SMS Services Inc reports that more than 1,500,000 new uniform claim forms have already been sold and distributed. Physicians and clinics are ordering so many of the forms, in fact, that SMS Services has all it can do to keep up with the demand! Surgical Care-Blue Shield has informed SMS that it will endorse the new form. All other insurance carriers in Wisconsin continue to accept the uniform claim form, but do not endorse it.

MDS

Durkin criticizes rate review program. Wisconsin's new rate review program was strongly criticized and called "ineffective" by Robert Durkin, administrator of the State Division of Health, at a rate review meeting recently held in Milwaukee. Durkin said while the program is supposed to be a mechanism for controlling costs, he sees it as a tool to approve costs. "We slice off a nickel here and a dime there and every once in awhile a dollar, and this is good. But we will never really save dollars until we face up to the situation of excess capacity of hospital facilities," Durkin said. The rate review program is operated by representatives from Blue Cross, the Wisconsin Hospital Association, and the State, and acts on all rate requests from hospitals in the state.

Generic drug law saved $100,000, researchers say. Researchers have estimated that consumers saved about $100,000 during the first year that Wisconsin's generic drug law was in effect. The researchers base their claim on examinations of 20,000 prescriptions filled at 114 Wisconsin pharmacies during the past year. In addition, the potential for savings, they say, is far greater — $4 million to $6 million per year. Researchers say allowing substitutions for a larger number of drugs will increase participation in the program and eventually lead to a change in the drug-buying habits of pharmacists.

New rules challenge doctor-patient confidentiality. The American Medical Association has urged revision of rules proposed by the Occupational Safety and Health Administration, saying that they would pose a threat to traditional doctor-patient confidentiality. The rules, aimed at guarding employees against health hazards while at work, would require each employer to keep a daily log of employees' on-the-job injuries and job-related health problems. The AMA said that such records often contain personal data unrelated to the workplace and that the logs would be open to inspection by all employees.

Medical school enrollment hits new peak. Total enrollment in the 122 US medical schools in 1977-78 was 60,456, an increase of 2,190 over the previous year, according to the AMA's 78th annual report on medical education. By the end of 1977 the total number of medical and osteopathic physicians had reached 437,000, with an annual growth rate of 3.5 percent. The US population is growing much slower, at a rate of 0.7 percent. Ratio of doctors to population has jumped from 149 per 100,000 in 1960 to 198 per 100,000 at the end of 1977. Total medical school enrollment has doubled in the same period, from 30,000 to 60,000. The number of graduates has doubled and the number of medical schools has increased from 86 to 122. Still more schools are in the process of development. ■

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State Medical Society of Wisconsin

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* the official publication of the Society.

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294719

OCT 16 1980

Editorials

Editorial Director: WAYNE J BOULANGER, MD

Comparison of national health systems

PRESIDENT CARTER and Senator Kennedy are sharply divided on the method of implementing national health insurance. It has become a popular political ploy to import selected proponents and opponents to testify at hearings relative to national health insurance.

A means of rebuttal was conceived by the American College of Surgeons at its recent annual Clinical Congress. Panelists from England, Canada, and Australia compared national health systems in their respective countries.

Mr Peter H Lord, FRCS of England stated, "You can all sit back and relax, you're not going to get a health system like the British National Health System. The NHS is not for export. You couldn't have one here even if you wanted one." He went on to explain that the NHS began in 1948 following World War II and that everyone in the country accepted it. He said, however, that the system has led to stagnation because individuals and institutions are not paid for work done in a competitive situation. He advised that physicians here avoid centralized control of health care because in the long-term, total government control eliminates all true competition and built-in incentives to do well.

A second panelist, Walter C MacKenzie, MD, FACS of Canada stated that any kind of national health system is a deterrent to innovation. He said that health care in Canada has become "all politics." He urged US physicians to try to influence politicians to avoid the abuses that have resulted in his country: overuse of services and overdemand for health care. He said that while the medical profession has no argument with the social intent of the program, doctors are discontented with their inability to manage the health system. The effect on the profession and the quality of care may be catastrophic, he said. Doctor MacKenzie also said that in Canada there is a first-dollar national insurance for acute care hospitals but not for extended care facilities. Therefore, patients prefer to use acute care hospitals when that type of care is not necessary.

The third panelist, Mr H D'Arcy Sutherland, President of the Royal Australasian College of Surgeons, echoed similar concerns about the overuse of services and overdemand on the system in Australia. He said that about 77% of the health care in Australia is financed by government, and health costs have risen. He also said that psychology of dependence has developed with no sense of personal responsibility within the system. Patients are now making demands on the system that are too costly.

In the meantime, back on the Potomac, there seems to be a race to legislate a package that would require mandatory and comprehensive coverage for all Americans, with protection against catastrophic medical expenses, strong cost control mechanisms, and a combination of government and private financing. The experiences from abroad should certainly be heeded in any of these plans.—VSF

A 5.8 percent solution

ALONG ABOUT THIS time, physicians have to be feeling a bit defensive about their alleged responsibility for the high cost of health care as they dodge shots from news media, government agencies, and Senator Kennedy. That is why it was especially reassuring to listen to Robert Durkin, administrator of the State Division of Health, as he spoke at the annual meeting of the Wisconsin Chapter of the American College of Surgeons last October.

Mr Durkin reported that the price tag on Medicaid in Wisconsin will hit 600 million dollars this year. Fifty-seven percent of that total will be spent on nursing home care for 32,000 people. Drugs will cost 5.6%, and 3.3% will be spent on dental care. Physicians' fees will amount to 5.8%.

The public, of course, sees headlines about Medicaid fraud and envisions doctors making off with truckloads of lucre. In actuality, the 5.8% figure includes all physicians' fees, honestly as well as dishonestly assessed—a paltry sum by government standards. Medicine's antagonists advocate control of fees to solve the problem of

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

escalating costs. Should controls be set at a level where doctors were not paid at all, it would still only be a 5.8% solution.—WJB

Who's on first?

RECENTLY THE Secretary of HEW annnounced the appointment of a young physician as director of the National Institute of Occupational Safety & Health. In this position he will provide scientific leadership to the Institute, which has a budget of 66 million dollars and 900 employees.

The young physician has an impressive *curriculum vitae*. He is a graduate of a prestigious eastern medical school and also has a master's degree in public administration from Harvard University's JFK School of Government. He has served in several administrative positions in a number of states.

The question that came to my mind after reading all these credentials was, "But has he ever practiced medicine?" This appears to be the typical bureaucratic situation in which an individual who has had little or no clinical experience is put in a position of telling clinicians how to go about their business.—VSF ■

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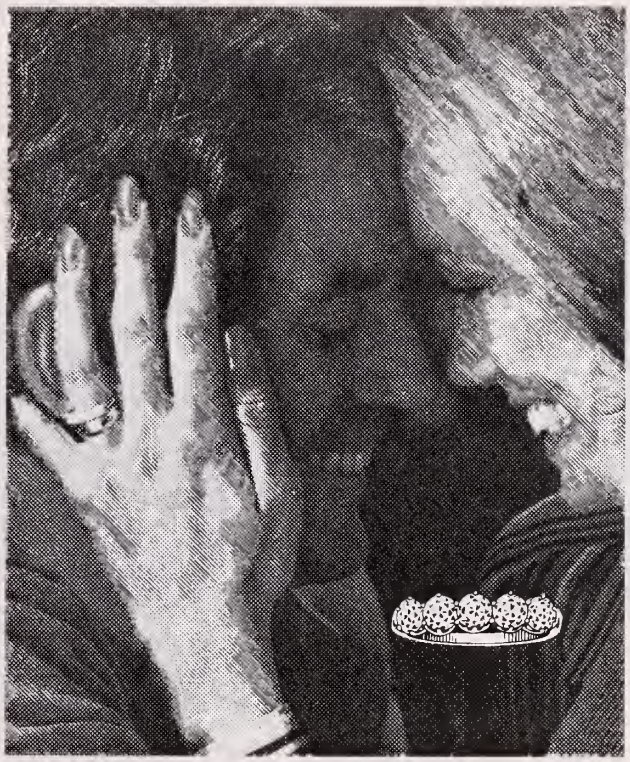

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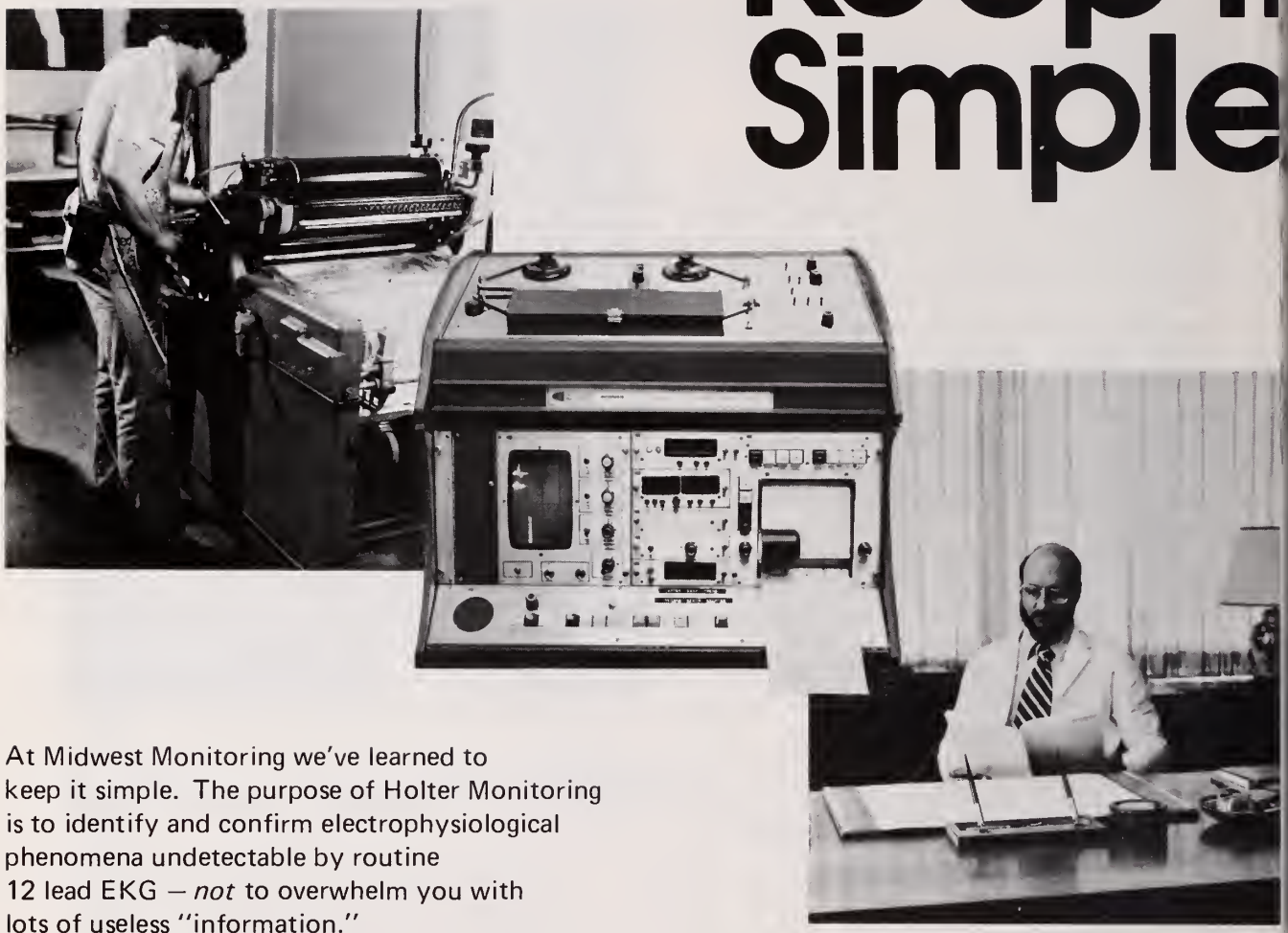

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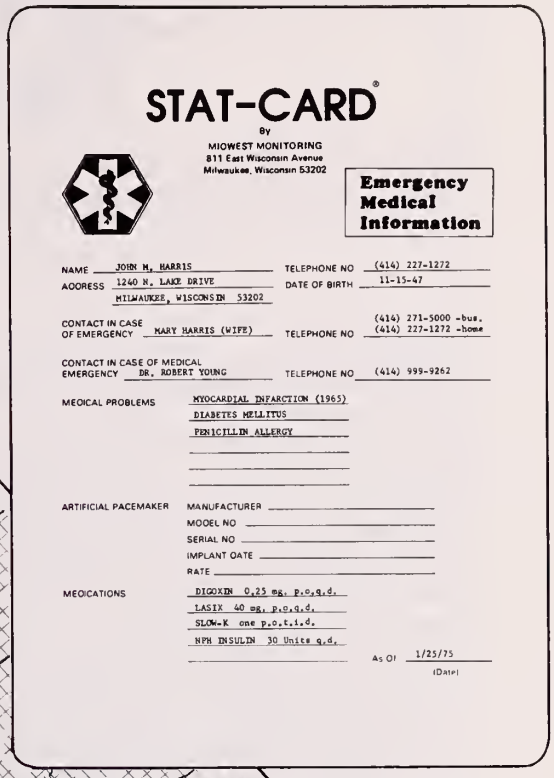

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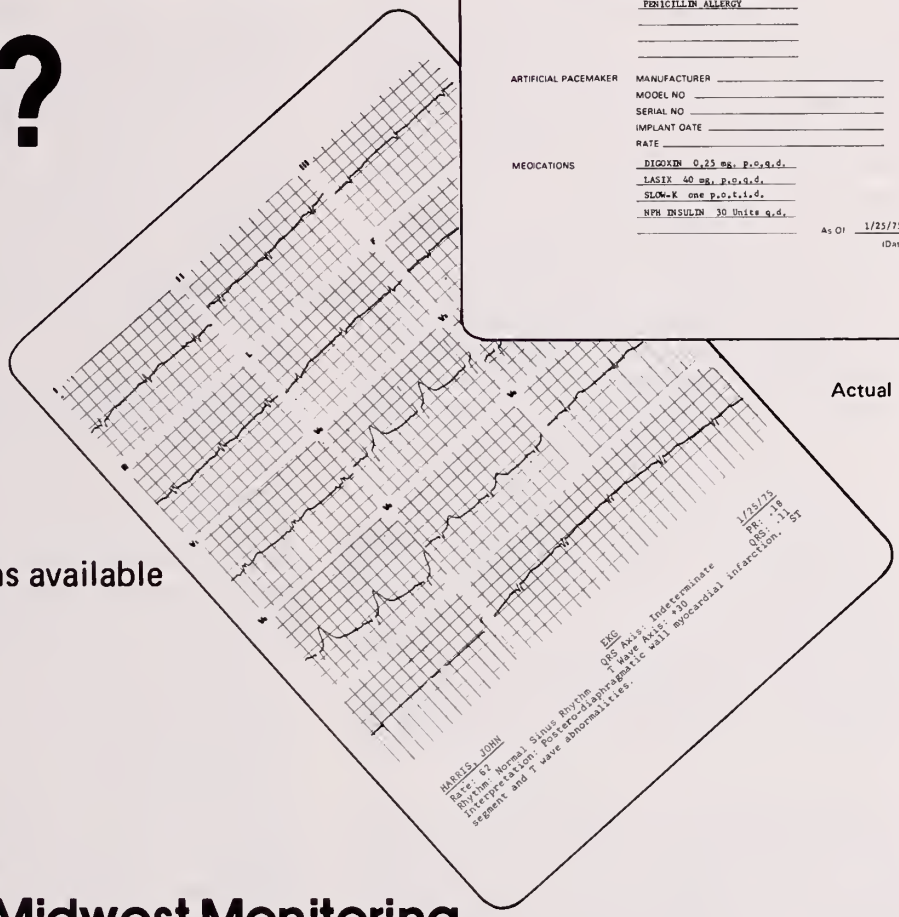

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Opinion/Dialogue

Lawyer-physician relationships

As PHYSICIANS working with medicolegal problems, we have been consistently amazed and disappointed to learn through referrals to our Committee of the relationship (or lack of it) between insurance company lawyers and physicians in medical liability cases. Certain points of legal ethics seem to arise:

- Does the lawyer owe less to a client if the lawyer is paid by the insurer?
- Does the insurer have the right to throttle a vigorous defense preparation by the defendant-physician's attorney by virtue of the carrier's internal policy and available funds?
- Does the insurer's lawyer have the latitude to direct and control the defense on the merits of the case independent of the financial implications to the insurer?

We cannot avoid seeing an analogous medical ethics question as it relates to the doctor/patient relationship: When a patient has not been informed of a diagnosis, prognosis and the treatment, has not our system failed? We say, "Yes." When the defendant-physician has not been consulted by the insurance-company-appointed lawyer and advised of the status and future of his/her case, has not the legal system failed?

Medical liability cases are life and death struggles for physicians. We feel our professional life is at stake. Physicians are not accustomed to battle in the courtroom. We do, in fact, often struggle to save the lives of our patients, but our battleground is our offices and hospitals.

When a physician believes that a malpractice action is started and continues without cause, this courtroom struggle can act as if it were a cancerous growth. In this atmosphere and with the necessary and inherent delays in the courtroom life of the case, is it really surprising that many physicians conclude that a vigorous defense is not forthcoming. The question frequently becomes, "Is any defense at all being offered?"

This is not to say that malpractice does not occur. We believe that it does. We also believe that these plaintiff-patients should receive an adequate and fair compensation. There is little doubt, however, that frivolous and nuisance suits do exist. Our studies in medical liability cases from the summons/complaint stage to the termination/settlement conclusion have established the fact that insurance companies do "settle" complaints by agreeing on payment to the plaintiff-patient when medical wrongdoing has not been established or proven. For a defendant-physician this is often thought to be unconscionable.

Certainly physicians are concerned with their professional image. We believe ethical lawyers are concerned with their professional image as well. As in the medical profession, lawyers need to be able to spend time *listening* to their clients. Is not the listening stage one of the primary means of developing an adequate defense? How can there be any substitute for contact with a client? Is it really asking too much to expect? Is it not worth the effort? Would it not contribute greatly, and with minimal effort, to improving your BAR IMAGE as well as your professional standings?

These questions are not strangers to the medical profession. We wrestle with them daily. It appears to us that the problem of the all-too-often nonexistent relationship between lawyers and the physicians they represent in malpractice cases has an easy solution: your time and attention, coupled with a vigorous, uninhibited defense. Physicians are becoming increasingly aware of the importance of their patients' attitude toward them. Are not lawyers cognizant of the significance of their clients' attitude toward them?

Meetings between lawyers and physicians have been ongoing in Wisconsin since 1975 in an attempt to identify issues and answers in the "malpractice crisis." We wonder what has been learned over this time span. Have our efforts been expanded for naught?

The legal profession owes the physician the same vigorous defense provided to others who do

not have an insurance intermediary. Anything less seriously erodes the necessary interprofessional relationship between physicians and attorneys. Comments and methods to remedy the present situation are solicited.

RUSSELL A QUIRK, MD, Chairman
Medical Liability Committee
Physicians Alliance Commission
State Medical Society of Wisconsin
Box 1109, Madison, Wisconsin 53701

THE INTERPROFESSIONAL and Business Relations Committee of the State Bar of Wisconsin has reviewed the (above) article written by Russell A Quirk, MD, chairman of the Medical Defense Committee of the State Medical Society of Wisconsin; considered the comments of the joint meeting of the two committees, and submits the following comments from the lawyers' viewpoint.

It appears that one of the greatest failings by lawyers representing insurance companies for doctors in the malpractice field is lack of communication between the lawyer and the doctor to keep the doctor informed as to exactly what is being done and what procedures are being used to accomplish this.

In many instances it seems that the doctor takes out his animosity, at being involved in a lawsuit and having his professional ability questioned, on the attorney who is representing his insurance company. The doctor often feels that every hearing, deposition or other conference is an infringement upon his personal rights and does not understand why he should have to be subjected to these time consuming steps.

It is absolutely essential for the medical profession to realize that there are certain steps which must be followed in either the prosecution or defense of a lawsuit, and that the rules of the game cannot be changed to accommodate the defendant just because he happens to be a doctor. It is absolutely essential that the doctor realize the lawyer also has a very busy schedule and, when appointments are made with the lawyer, the doctor should make every effort to honor the appointment so as to not waste time of the lawyer involved. He also should realize that, when he is required to attend a deposition, he should rearrange his schedule accordingly and review all documents beforehand so that he is fully prepared to testify at the deposition.

It is also essential that the lawyer keep his doctor-client fully advised as to what is happening, why it is happening, and to reasonably acquaint him with what to expect in the defense of the lawsuit. It is also important that the doctor know that court schedules change; that the attorneys have little or no control over these changes and that schedules are necessary for the courts to accommodate the extremely heavy case loads they have today. This means that the doctor may have to adjust his office appointments and scheduled surgery time to accommodate this. On the other hand, the lawyer must make every effort to give all possible advance notice to the doctor so as not to disrupt his schedule unnecessarily.

The doctor should also realize that when recommendations are made for minimal settlements, in order to avoid the prolonged defense of the lawsuit which involves both time and money, this advice should be given strong consideration by the doctor. Most insurance policies provide that settlement of these cases cannot be made without the written approval of the doctor but in considering this question, the doctor should consider the fact that the lawyer is, by law and by the terms of the insurance contract, bound to give his first allegiance to the doctor rather than to the insurance company; and such recommendations by the lawyer should be considered as being made with the best interest of the doctor in mind. While the doctor frequently has the right to reject the advice of the lawyer and to insist on trial in any event, he should certainly give proper respect to the advice of his counsel the same as he would expect the lawyer to give great weight to the doctor's advice to that lawyer were he his patient with respect to matters of medical treatment.

Our committee feels that joint meetings between the local chapters of the State Medical Society and the State Bar Association could be very helpful and go a long way toward breaking down the communications barrier that still exists, to some extent, between our two professions. Communication is the name of the game and if we can establish anything, both societies will benefit. Comments from either doctors or lawyers will be welcomed.

ROBERT C VOSS, Chairman
Interprofessional and Business
Relations Committee
State Bar of Wisconsin
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EDITOR'S NOTE: The above two communications of Doctor Quirk and Mr Voss also are appearing in the December-January issue of the *Bar Bulletin*. ■

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Letters

"Ted Kennedy's soap opera"

I HAVE ENCLOSED a recent editorial from the *Chicago Tribune* describing Mr Kennedy's biased and partial hearings on medical care. I believe this information contained should be widely distributed to all politicians and physicians so they are fully aware of what Mr Kennedy is trying to do. I am sure you are aware that in recent meetings in Michigan the State Medical Society was not even allowed to testify and similar techniques were carried out in Illinois and elsewhere. Certainly, this method of operation should be widely exposed to the public since I think they will understand that Mr Kennedy's motives are more political for his own self-gain, rather than in improving health delivery systems.

G LEONARD APFELBACH, MD
Janesville, Wisconsin

The following editorial is reprinted from the *Chicago Tribune,* December 3, 1978:

Ted Kennedy's soap opera

Medical case histories are the dramatic stuff of soap operas—and of political hearings—as Sen. Edward Kennedy (D., Mass.) knows full well. He stacked his Senate subcommittee's Chicago hearings on national health insurance with six Illinois witness and six Canadians who gave carefully matched accounts of catastrophic illnesses. Sure enough, on this Kennedy version of "General Hospital," the Americans faced severe financial strain and the Canadians got home almost free because of Canada's national health plan.

The episodes in Mr. Kennedy's show were picked, of course, to fit the remedy the senator already has in mind: national health insurance for the United States. Having the federal government pay all of our medical bills would, indeed, help millions of us—particularly those who are un- or under-insured or confronted with unusually complicated or chronic problems. But like amputating a leg because it's broken, it's too drastic a remedy for what can be resolved in other ways. And the cure can be far worse than the disease.

Mr. Kennedy is right when he says that medical costs are too high in the United States and have been increasing out of proportion to other costs of living. By his calculations, 26 million Americans now have no health insurance and 19 million others are inadequately covered; for many of them, major illness could bring financial disaster. Nor is access to medical care uniform; rural and inner city areas tend to be short of physicians.

But would a health system like Canada's solve these problems? Spending for medical care has grown even faster in Canada than in the United States since Canada started its program to cover hospital costs in 1958 and a second plan to pay physicians' fees in 1968. Medical care is still inadequate in the inner cities and in rural areas. Soaring costs have forced the Canadian national government and provincial governments, which share health care financing, to cut back on services. Many health needs are still not included in the programs. Small fees are now charged for some care. And one out of every two Canadians now buys private health insurance to supplement government programs.

Canada's plan has also had some unhappy side effects. Taxes have had to be raised, but the government deficit is growing even so. Because of the resulting inflation, Canada's dollar is one of the few currencies in worse shape than ours. Cutbacks have been made in other welfare programs so tax money could be shifted to health care. Waiting times for medical treatment have increased, although this is not as great a problem as in Great Britain. And emigration of doctors to the United States is increasing.

Most of these problems would plague any federal health plan in the United States. But the biggest objection is simply that the massive federal bureacracy cannot do the job efficiently and well.

Letting the federal government move into health care in any bigger way would require increased taxes, accelerate inflation, impose more layers of red tape on hospitals and doctors already choking on paperwork, and in the long run, cost all of us more money and time. Four out of five Americans are already adequately insured against medical costs, by Kennedy's own statistics. There are better ways to help those who can't get insurance for themselves. No amount of soap opera should psych us into agreeing that amputation is the way to cure a broken leg. ■

In Perspective

SMS Staff Coordinator: BRIAN JENSEN
Director, Physicians Alliance Division

Political division of Government offers new challenge for medicine

ONE OF THE FAVORITE pastimes of the Capitol Press Corps during the past six weeks has been speculation about the ability of the newly-elected Republican Governor and the Democratically controlled Legislature to work together in the upcoming legislative session. It has been some time since Wisconsin has experienced such a division of government; but the current division is unique due to the almost unprecedented character and style of the new Governor and the emergence of an activist legislature.

One aspect of the Dreyfus approach which was brought out by the candidate interviews conducted in July by the WISPAC Board was the demand for "facts." While any candidate for public office has at times relied upon rhetoric, Dreyfus was overly insistent upon factual documentation of the Society's position on issues. Emotionalism, it seems, will not work with the new Governor.

This is not surprising, however. Over the past several sessions, individuals elected to the Legislature have been making similar demands upon organizations with lobbying responsibility. For example, we have seen more and more legislators react negatively to the "chiropractic is quackery" argument and more and more to positions based upon premium costs, patient free choice, and constituent demands for services. The emergence of a full-time Legislature, complete with staff attorneys, research assistants, fiscal analysts, and the like pose a true challenge to lobbying personnel from the private sector.

This trend of *more* information and *more* facts renders "old style" politics just that: out of date.

For the Physicians Alliance and the State Medical Society, these developments and the election of a Governor from the party other than that which controls the Legislature means the following:

1. More than ever before the ability of the Society to present factual, detailed justification for its positions will in large part determine its level of success in the political arena.
2. Physicians active at the local level with legislators will be faced with the same demands; a situation which requires extremely close coordination and communication with the Society's membership.
3. The Society has an opportunity to distinguish itself as a front-runner among this "new breed" of lobbying organizations by adherence to a system which avoids emotional rhetoric and insists upon sophisticated and factual presentations before the Legislature and the Governor.

This challenge is one which can be met with the help of physicians active in the Alliance-legislator contact system. To fail to meet it poses serious consequences for the future of medicine in Wisconsin. ■

Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Breast cancer prognosis and estrogen receptors

ALTHOUGH BREAST CANCER is the most common cancer in white women over 40 years of age, there are still many questions about what is the best and most appropriate treatment. How can patients be selected so that effective treatment can be instituted before dissemination? And when should that treatment be commenced? Hormones have long been known to have an effect both on the growth and development of breast cancer. Ablative hormonal treatment (oophorectomy, adrenalectomy, hypophysectomy, or anti-hormones such as tamoxifen) has a favorable effect on about one-third of all patients with metastatic disease, but the tumors in the other patients continue to grow in an autonomous manner.

A significant advance was made when receptors for the female hormone estrogen were found in normal tissues from the breast, endometrium, vagina, and hypothalamus and pathological tissue from breast cancer, uterine cancer, malignant melanomas, and some cancers of the kidney. These receptors are cytoplasmic proteins which bind estrogen strongly and specifically. The interaction of the estrogen steroid with the receptor protein is believed to be the initial event in a series of responses characteristic of estrogen stimulation.

About 61% of breast cancers in premenopausal women and 75% of those in postmenopausal women are estrogen receptor positive (ER+). The median age of ER—women is 9 years younger than that of ER+ patients. Between 55-60% of breast cancer patients who are ER+ respond to endocrine treatment. Patients who are ER− have a response rate less than 10%. Therefore, ablative procedures will cause tumor regression in only about 30% of the patients. Because not all women treated by mastectomy develop metastases and only about 30% of those who do will derive benefit from ablative procedures, three useless oophorectomies will be done for each beneficial one. Responsive tumors seem to be sensitive to a change in the endocrine environment, not to a specific hormone treatment, and estrogen receptors seem to be needed for the tumor to be sensitive to these changes. Not only do ER+ patients respond better to endocrine therapy, but they appear to have a survival advantage.

Dr William Knight and coworkers at the University of Texas Health Science Center in San Antonio recently reported that patients with ER− primary breast tumors showed an increase in early recurrence, independent of other known prognostic factors such as size of the primary tumor, location of the tumor, number of involved axillary lymph nodes, or age. These patients constitute a very high risk group.

Those breast tumors which are ER− or respond to chemotherapy have a higher growth fraction and, therefore, are more likely to suffer an early recurrence. ER− tumors which recur early are more common in premenopausal patients; their growth is affected more by chemotherapy than tumors in postmenopausal patients which grow more slowly.

An ER− test may prove to be a useful predictor of a favorable response to adjuvant chemotherapy. ER+ tumors may not benefit as much from adjuvant chemotherapy because of more chance of a low growth fraction and a delayed recurrence; perhaps in these cases some form of endocrine therapy such as tamoxifen is indicated.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

Over the past four years Drs David Rose and Lina Liskowski, at the Wisconsin Clinical Cancer Center in Madison, have been testing samples of breast tissue obtained from Wisconsin women at the time of mastectomy for ER activity; approximately 1200 assays are performed each year. They would now like to see if the ER− women have indeed had earlier and more frequent recurrences. If one of your breast cancer patients has been tested for ER activity at the Center, you will soon be receiving a questionnaire requesting information of subsequent recurrences and site of recurrence. If these results on Wisconsin women confirm the results reported by Knight et al, then it may indeed be possible to develop a more rational approach to the treatment of breast cancer.

Since the breast cancer patients who are ER− and node positive are a high risk group which has a 50% recurrence rate at 18 months, they are usually treated aggressively with combination chemotherapy immediately after mastectomy. In an intermediate risk group are patients who are ER+ and node positive; they may respond best to endocrine therapy with or without chemotherapy. Another intermediate risk group are those who are both ER− and node negative; despite the absence of lymph node involvement, adjuvant chemotherapy may prove to be indicated in this group. Patients who are ER+ and node negative belong to a low risk group; the current belief is that adjuvant chemotherapy is not indicated.

Even after these studies, many questions will still remain. For example, how can the ER+ patients who will not respond to endocrine manipulations be identified? It has been suggested that those tumors which contain progesterone receptors are truly hormone responsive and will benefit from endocrine treatment. Approximately 56% of breast cancers contain both estrogen and progesterone receptors. Progesterone receptors are rarely present in ER− tumors. About 85% of tumors which have both receptors respond to endocrine treatment. Apparently estrogen receptors are necessary for the synthesis of progesterone receptors. Estrogen combines with the ER in the cytoplasm, then moves to the nucleus where its action is expressed. If this occurs, the pathway for the synthesis of progesterone receptors is possible. The presence of both receptors indicates that the necessary endocrine machinery is present and the tumor under partial endocrine control; this apparently increases the likelihood of a favorable response to treatment.

With your cooperation and that of other physicians around the world, some of the answers to these difficult questions concerning the best treatment of breast cancer will be determined. Hopefully such endocrine receptor measurements will help guide therapy by helping select patients who should receive endocrine and/or cytotoxic treatments at the time of the first treatment rather than waiting for recurrence.

—Dorothy J Buchanan-Davidson, PhD
Science Writer ■

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

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Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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Scientific Medicine

Medical Editor: VICTOR S FALK, MD

Refer to: Norfleet RG, Roberts RC; Hemoccult screening for colorectal neoplasms; report of a pilot project. *Wisconsin Med J* 78:25-27 (Jan) 1979

Key words: Hemoccult screening, colorectal neoplasms, cancer, Hemoccult II® kits

Hemoccult screening for colorectal neoplasms: report of a pilot project

Robert G Norfleet, MD and Ronald C Roberts, PhD
Marshfield, Wisconsin

• We attempted to screen 492 members of a prepaid health program for colorectal neoplasms by use of Hemoccult® II slides. In a program conducted entirely by mail, 236 patients (48%) returned properly completed test slides. Fifteen (6%) of these patients returned slides that were positive for occult blood; and 14 of these patients completed subsequent investigation to determine the source of bleeding. Findings included hemorrhoidal bleeding in five patients, anal fissure in one, gastritis in one, no detectable disease in two, and neoplasms in five. The neoplasms included three benign adenomas larger than 0.7 cm, one large adenovillous sessile neoplasm, and one 2.5 cm villous adenoma with atypia. Cost of the screening portion of the program was $195 (about 39¢ for each kit mailed, or 83¢ for each patient who participated). The evaluation of those with positive stools cost $3,946, and treatment of the five neoplasms cost $4,787. Judging this program as practical, successful, and needed, we plan to continue it and hope to improve our results of therapy for this common and often dreadful disease.

After cancer of the skin, cancer of the colon and rectum is the most frequent cancer in the United States. Nevertheless, treatment has not improved in the past 30 years. There is probably a long "latent" period from the beginning of colorectal cancer until symptoms appear.[1] Because the rate of cure is directly related to the stage of disease at the time of treatment, prognosis should be improved by earlier detection. Of the many diagnostic tools at our disposal we selected the Hemoccult II® slide test for occult blood in the stool to screen 500 randomly selected members of the Greater Marshfield Community Health Plan (GMCHP). This is a report of this project.

From the Section of Gastroenterology and Research Department, Marshfield Medical Center.

Study supported by the Wood County Unit and the Wisconsin Division of the American Cancer Society.

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Methods

Five hundred members of the GMCHP 40 or more years old were randomly selected by computer to participate. Adherent labels were printed with the name and address of each participant. Also, a "master sheet" was produced listing the participants alphabetically with space to record the response and results. The Wisconsin Division of the American Cancer Society provided the Hemoccult II® kits (Smith Kline Diagnostics, Sunnyvale, CA 94088) which included the guaiac impregnated test slides, return envelopes with instructions printed inside, wooden sticks, and developing solution. The Wood County Unit of the American Cancer Society provided funds for postage and printing as well as volunteers to assist with addressing and mailing the test kits and processing and tabulating those which were returned.

This detection program was designed to be completed entirely by mail. A letter was written to explain the project and its importance and to supplement the instructions on the return envelope. No special diet was requested. The initial mailing was prepared in September 1977 by seven volunteers in about two hours. Bulk mailing rates were utilized to send the kits out while the return envelopes were pre-stamped.

The return slides were processed daily by one to two volunteers which required a total of 20 hours. To avoid false negative results, stools dated four days before developing were moistened with tap water prior to developing as recommended by Wells and Pagano.[2]

Participants with a negative test result were not notified. Those with positive reactions were notified with a second letter explaining the importance of prompt evaluation without frightening the participant. A postage-paid card was enclosed to be returned with the name of the participant's doctor. If the patient did not have a physician whom he or she could see promptly, this was indicated on the card and an appointment arranged. The physician was notified by letter that his or her patient had test results positive for blood in the stool. The letter suggested a brief interview to determine whether the patient had any obvious bleeding source or had ingested aspirin during the period of stool collection. If not, digital examination of the rectum and a proctoscopic examination were recommended. Next, a barium-contrast roentgenologic examination of the colon was suggested. If a source of the bleeding was not identified by these procedures, a barium-contrast examination of the upper gastrointestinal tract with small bowel followthrough was advised. Finally, colonoscopy was recommended before the test could be considered falsely positive.

Table 1—Lesions found in 14 patients exhibiting positive Hemoccult tests

	Patients
Hemorrhoids—	
gross bleeding	3
Asymptomatic	2
Anal fissure	1
Gastritis	1
Neoplasms	5
False positive	2
TOTAL	14

Table 2—Expenses for screening 500 people for occult blood in the stool

500 Hemoccult II® kits	$ 85.00
Postage (bulk rate)	10.50
Return postage	65.00
Printing costs	32.00
Followup letters	2.50
TOTAL	$195.00

Results

Of 500 testing kits mailed, 8 were returned because of a wrong address. Of the 492 kits that reached the patient, 236 were returned and promptly completed, a compliance rate of 48%. Slides from 15 participants (6%) were found to have occult blood on at least one of the six test openings. Fourteen of these 15 participants returned the followup card and participated in the recommended screening program, a followup compliance rate of 93%.

Three of the 14 patients with positive stools gave a history of hemorrhoidal bleeding (visible blood on wiping but not on the stool) which was confirmed by rigid or fiberoptic proctosigmoidoscopy. Six patients completed the recommended followup without a finding of any significant lesion except friable hemorrhoids (2 patients), anal fissure (1 patient), and gastritis (1 patient).

Five patients were found to have a neoplasm. Of these, three had a benign adenoma larger than 0.7 cm, one had a 2.5 cm villous adenoma with atypia, and the fifth patient had a sessile 5 x 7 cm adenovillous tumor that did not contain cancer. The patients with neoplasm were 43, 48, 53, 56, and 57 years old. All the neoplasms were located in the sigmoid colon and were discovered with either rigid sigmoidoscopy (1 patient) or fiberoptic sigmoidoscopy (4 patients).

All patients were asymptomatic except the three with a history of hemorrhoidal bleeding. Table 1 summarizes the findings in all 14 patients.

Costs

The total cost of the screening project was $195, about 39 cents for each kit sent, or about 83 cents for each who performed the test. Table 2 shows the breakdown of screening expenses.

These costs do not include the time generously given by volunteers. No physician time was required for this portion of the program.

Costs for evaluating the 14 patients with positive Hemoccult II® slides are shown in Table 3.

The cost for treating the five patients with neoplasms was $4,787. Four patients were treated with electrosnare polypectomy through the fiberoptic colonoscope without admission to the hospital. All had previously had diagnostic fiberoptic sigmoidoscopy and were not charged again for this procedure. The patient who had a large, sessile adenovillous polyp underwent an anterior resection requiring hospitalization, total expense of which was $4,022.

Table 3—Expenses for evaluating 14 patients with hemoccult-positive stools

Procedure	*Number Done*	*Cost Each*	*Cost*
Brief exam	14	$ 13	$ 182
Rigid proctosigmoidoscopy	2*	40	80
Fiberoptic sigmoidoscopy	11	50	550
Barium Enema	11	59	649
UGI and small bowel series	5	91	455
Colonoscopy	5	360	1800
Gastroscopy with biopsy	1	230	230
TOTAL			$3,946.00

*One additional patient had proctoscopy performed a month before the screening program. The examination was not repeated.

Discussion

There are several reports on screening for colorectal neoplasm by testing the stool for occult blood.[3-6] The results of these are not comparable to the present study as they all required the patient's at

tendance to receive instructions and the testing kit. This is selective because the patient must be interested and motivated in order to enter the study.

Our pilot study demonstrates that it is possible and practical to screen large groups of people for colorectal neoplasms in a program conducted entirely by mail. Although Elwood, et al[7] found the "total mail out" method had a return rate of 15.4% while meeting with groups and distributing Hemoccult kits produced a return rate of 28.7%. Our cost of 83 cents per patient screened is very attractive. A population participating in a prepaid health program may be especially compliant, particularly in followup of a positive test, because the financial constraints are removed.

We will continue this program, planning a modification to evaluate the use of a high-bulk, meat-free diet for those with a positive stool on the initial screening test as advised by others.[3-4]

We are enthusiastic and hope that earlier detection of colorectal neoplasms will improve the present results of therapy. We will be pleased to share our technique with any interested physician and hope the Hemoccult II® detection method will be widely used.

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Refer to: Lang GE, Drozda Jr EA: Survey of blood ordering practices for 12 elective surgical procedures. *Wisconsin Med J* 78:27-31, Jan 1979

Key words: Crossmatch-transfusion ratio, type and screen, maximum surgical blood ordering schedule

Survey of blood ordering practices for 12 elective surgical procedures

Gordon E Lang, MD and **Edward A Drozda Jr, MT(ASCP)**

Milwaukee, Wisconsin

• The blood ordering practice for 12 elective surgical procedures performed at 13 Milwaukee hospitals was surveyed. There were 10,448 units of blood crossmatched for 4,823 operations. There were 3,216 units transfused for a crossmatch transfusion ratio of 3.25. The data supports the opinion of others that an excessive amount of blood is being crossmatched for elective surgery. Physicians should establish preoperative crossmatch guidelines and should consider the use of the type and screen in lieu of a crossmatch for those operations in which the possibility of significant blood loss is remote. This will result in a considerable monetary saving, a decrease in the incidence of blood outdating and an improvement in blood availability, all without jeopardizing the patient.

MINTZ et al,[1,2] Friedman et al,[3] and Henry et al[4,5] have reported that an excessive amount of blood is being crossmatched for elective surgical procedures. Mintz et al[1] reported that 213 units of blood were crossmatched for 97 consecutive cholecystectomies which were performed in 1974 at the State University of New York Upstate Medical Center. This is an average of 2.2 units per cholecystectomy. Only 5 units were transfused. Friedman et al[3] revealed that a similar number were crossmatched at the University Hospital in Ann Arbor. All of these authors have indicated that this practice results in an increased number of units of blood that outdate, an in-

Presented before the Wisconsin Surgical Society at the Annual Meeting of the State Medical Society of Wisconsin, April 15, 1978, Milwaukee. Doctor Lang is Chairman, Transfusion and Transplantation Committee, Medical Society of Milwaukee County; and Pathologist, St Mary's Hospital, Milwaukee. Mr Drozda was Medical Technologist, St Mary's Hospital, Milwaukee. Reprint requests to: Gordon E Lang, MD, Clinical Laboratories, St Mary's Hospital, PO Box 503, Milwaukee, Wis 53201.

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creased cost to the patient, and a decreased availability of the blood for other transfusions.

In view of the above studies, the Transfusion and Transplantation Committee of the Medical Society of Milwaukee County conducted a survey of the blood ordering practices for 12 different elective surgical procedures at 13 area hospitals. The survey was conducted between May 1, 1977 and October 31, 1977. It was hoped that the information gained by the survey, if similar to that already reported, might be used to establish blood ordering guidelines, which if implemented, would result in a monetary saving to the patient or his insurance carrier and improve blood utilization for the community without jeopardizing in any way, the welfare of the patient.

Methods. Twenty-four Milwaukee area hospitals were invited to participate in the study. Thirteen elected to submit data. Participants were given tables on which they indicated the number of units of blood crossmatched prior to and during surgery, the number of units used during surgery, and the number used within the 24-hour postoperative period. All operative cases, even those in which no units were crossmatched, were included. The following operations were selected: cholecystectomy, gastrectomy, colostomy, breast biopsy, modified radical mastectomy, thyroidectomy, laminectomy, transurethral resection, myocardial revascularization, abdominal hysterectomy, vaginal hysterectomy, and dilatation and curettage. Data for the entire six-month period was submitted by six hospitals; the others submitted data for less than six months.

Results. Table 1 tabulates blood ordered and used by operation on a cumulative basis. There were 10,448 units of blood crossmatched for 4,823 operations. There were 3,216 units transfused for a crossmatch transfusion ratio of 3.25. If the 493 myocardial revascularization procedures, which used 2,475 units, are excluded from the totals, the crossmatch transfusion ratio soars to 8.25. The crossmatch transfusion ratio (C/T) is obtained by dividing the number of units crossmatched by the number of units used and provides an index which compares blood ordering to utilization.

Table 2 tabulates blood ordered and used by hospital for all operations surveyed. The range of the average number of crossmatches per patient for noncardiac procedures varies from 0.79 to 2.53. The range of the average number of units used per patient varied from 0.04 at hospital 2, to 0.51 at hospital 9. The C/T ratio varied from 4.05 in hospital 9 to 20.67 in hospital 2.

Table 3 indicates, by operation, the percentage of patients who received 0, 1, 2, 3-8, or 9 or more

Table 1—Blood ordered and used by operation

OPERATION	*Number of operations*	*No. units cross-matched*	*No. units used*	*Average No. units cross-matched per patient*	*Average No. units used per patient*	*C/T ratio*	*Range of units used per patient*
1. Cholecystectomy	593	827	70	1.39	0.12	11.81	0-5
2. Gastrectomy	74	238	58	3.22	0.78	4.10	0-5
3. Colostomy	60	147	21	2.45	0.35	7.00	0-2
4. Breast biopsy	420	457	21	1.09	0.05	21.76	0-2
5. Modified radical mastectomy	133	315	76	2.37	0.57	4.14	0-4
6. Thyroidectomy	103	109	4	1.06	0.04	27.25	0-4
7. Laminectomy	248	754	173	3.04	0.70	4.36	0-18
8. T U R P	527	990	86	1.87	0.16	11.51	0-4
9. Myocardial revascularization	493	4335	2475	8.79	5.02	1.75	0-30
10. Abdominal hysterectomy	694	1385	154	2.00	0.22	8.99	0-8
11. Vaginal hysterectomy	352	575	36	1.63	0.10	15.97	0-4
12. D & C	1126	316	42	0.28	0.04	7.52	0-6
All operations	4823	10,448	3216	2.17	0.67	3.25	0-30
All operations except myocardial revascularization	4330	6113	741	1.41	0.17	8.25	0-18

units of blood. Only 17% of the 4,823 patients undergoing the 12 operations studied required a transfusion of blood. This percentage was reduced to 9% if the 493 patients who had a myocardial revascularization were excluded. Only 1 of 103 patients who had a thyroidectomy was transfused, 109 units of blood were crossmatched for these 103 patients. Only 9.9% of the 493 myocardial revascularization patients did not receive blood. Of those that were not transfused

Table 2—Blood ordered and used by hospital

HOSPITAL	*Number of operations*	*No. units crossmatched*	*No. of units used*	*Average No. crossmatched per patient*	*Average No. units used per patient*	*C/T ratio*
1	729*	1867	922	2.56	1.26	2.02
	569**	468	66	0.82	0.12	7.09
2	799	2073	835	2.59	1.03	2.48
	660	682	33	1.03	0.04	20.67
3	282	534	164	1.89	0.58	3.25
	243	193	20	0.79	0.08	9.65
4	621	696	88	1.12	0.14	7.91
5	336	415	36	1.23	0.11	11.53
6	259	770	254	2.97	0.97	3.05
	211	366	48	1.73	0.22	7.63
7	186	384	49	2.06	0.26	7.84
8	85	168	13	1.98	0.15	12.92
9	468	1454	634	3.11	1.35	2.29
	412	854	211	2.07	0.51	4.05
10	523	1177	124	2.25	0.24	9.49
	472	977	77	2.07	0.16	12.69
11	365	535	63	1.46	0.17	8.49
12	128	266	29	2.08	0.23	9.17
13	43	109	8	2.53	0.19	13.63
All operations*	4823	10,448	3216	2.17	0.67	3.25
All operations except myocardial revascularization**	4330	6113	741	1.41	0.17	8.25

Table 3—Percentage of patients by operation who received 0, 1, 2, 3-8, or 9+ units of blood

OPERATION	*% 0 units*	*% 1 unit*	*% 2 units*	*% 3-8 units*	*% 9+ units*	*Average No. units used per patient*	*C/T ratio*	*Average No. units cross-matched per patient*	*Number of operations*
1. Cholecystectomy	94.3	1.6	3.2	1.2	0	0.12	12.16	1.39	593
2. Gastrectomy	68.6	13.2	17.6	7.9	0	0.78	4.10	3.22	74
3. Colostomy	78.9	8.7	12.3	0	0	0.35	7.00	2.45	60
4. Breast biopsy	96.9	0.8	2.3	0	0	0.05	21.76	1.09	420
5. Modified radical mastectomy	65.5	15.5	15.5	3.4	0	0.57	4.14	2.37	133
6. Thyroidectomy	99.0	0	0	1.0	0	0.04	27.25	1.06	103
7. Laminectomy	72.7	10.7	6.2	9.1	1.2	0.70	4.36	3.04	248
8. T U R P	87.5	7.1	4.4	1.0	0	0.16	11.51	1.88	527
9. Myocardial revascularization	9.9	4.1	12.0	61.6	12.4	5.02	1.75	8.79	493
10. Abdominal hysterectomy	89.9	3.8	3.2	3.1	0	0.22	8.99	2.00	694
11. Vaginal hysterectomy	94.1	2.4	3.1	0.3	0	0.10	15.97	1.63	352
12. D & C	98.3	0.3	1.1	0.3	0	0.04	7.52	0.28	1126

Table 4—Cholecystectomy—blood ordered and used

HOSPITAL	Number of operations	No. units crossmatched	No. units used	Average No. cross-matched per patient	Average No. units used per patient	C/T ratio	Range of units used per patient
1	86	50	9	0.58	0.10	5.56	0-4
2	62	103	0	1.66	0	∞	0
3	18	8	0	0.44	0	∞	0
4	57	59	7	1.04	0.12	8.43	0-2
5	47	35	1	0.74	0.02	35.00	0-1
6	49	80	7	1.63	0.14	11.43	0-2
7	41	83	10	2.02	0.24	8.30	0-4
8	21	24	1	1.14	0.05	24.00	0-1
9	68	139	18	2.04	0.26	7.72	0-4
10	63	137	9	2.17	0.14	15.22	0-5
11	59	62	4	1.05	0.07	15.50	0-2
12	13	29	0	2.23	0	∞	0
13	9	18	2	2.00	0.22	9.00	0-1
Totals:	593	827	68	1.39	0.11	12.16	0-5

62% had their surgery at one of the five hospitals reporting this procedure.

Table 4 indicates the amount of blood ordered and used for cholecystectomy by hospital. Hospital 1 crossmatched 50 units of blood for 86 cholecystectomies and used 9 units; whereas, hospital 10 crossmatched 137 units of blood for 63 similar operations and also used 9 units. Hospital 10 crossmatched almost three times as much blood per cholecystectomy. Similar data has been tabulated for the other eleven operative procedures studied and is available from the authors. This data indicates that there is also a considerable range in the number of units crossmatched and used for those procedures.

Discussion. The data indicates that there is a difference in the blood ordering practices in the Milwaukee hospitals surveyed. The mean 3.25 C/T ratio for all operations and the mean 8.25 C/T ratio for all operations except myocardial revascularization indicate that an excessive amount of blood is being crossmatched prior to elective surgery. The average use of blood was less than 0.5 units in 8 of the 12 operations. According to Mintz et al,[1] the preoperative crossmatch can be replaced by a type and screen in those operations in which the average use of blood is less than 0.5 units. The type and screen is a group of tests which determine the patient's ABO and Rho (D) type as well as the presence of unexpected red blood cell antibodies. When an unexpected antibody is detected, it must be identified; and if blood is to be transfused, the red blood cells must not contain the corresponding antigen. Unexpected antibodies occur in about one to two percent of the population. The type and screen is a safe alternative[6] for the "routine" preoperative one and two unit crossmatch that is ordered for those operative procedures which usually do not require transfusion. If a type and screen has been performed prior to surgery, fully crossmatched blood can be provided in about 30 minutes. In those rare instances of unexpected acute massive blood loss, in which the clinical situation does not permit time for a full crossmatch prior to transfusion, the type and screen assures that uncrossmatched ABO and Rho (D) type specific blood can be transfused with relative safety (99.99%).[6]

If the type and screen were utilized for the eight procedures that used an average of less than 0.5 units, a considerable reduction in cost would have occurred. There were 4,762 units of blood crossmatched for these eight operations and only 200 were transfused, for a C/T ratio of 23.8. Assuming that the average crossmatch cost $20.00 and the average type and screen cost $10.00, 3,875 patients would have been saved about $52,490.

Friedman et al[3] and Bear et al[7] have advocated that physicians establish a maximum surgical blood order schedule (MSBOS) as an effective way to reduce excessive preoperative crossmatching. A MSBOS lists all commonly performed procedures with the maximum number of units of blood to be preoperatively crossmatched for each procedure. They also advocate the use of a type and screen when the use of blood is remote. They suggest that the MSBOS be set up on a basis that the maximum number of units of blood that would be preoperatively crossmatched would

Table 5—Estimated effect of a MSBOS on blood ordering practices in Milwaukee

OPERATION	*Number of operations*	*Average No. units cross-matched per operation*	*Average No. units used per operation*	*No. cross-matches per case if MSBOS 95% was in effect*	*No. cross-matches per case if MSBOS 90% was in effect*	*Total No. cross-matches Mil-waukee survey*	*Total No. cross-matched if MSBOS 95% was in effect*	*Total No. cross-matched if MSBOS 90% was in effect*
Cholecystectomy	593	1.39	0.12	1	1	827	593	593
Gastrectomy	74	3.22	0.78	3	2	238	222	148
Colostomy	60	2.45	0.35	2	2	147	120	120
Breast biopsy	420	1.09	0.05	0	0	457	0	0
Modified radical mastectomy	133	2.37	0.57	2	2	315	266	266
Thyroidectomy	103	1.06	0.04	0	0	109	0	0
Laminectomy	248	3.04	0.70	3	3	754	744	744
T U R P	527	1.87	0.16	1	1	990	527	527
Abdominal hysterectomy	694	2.00	0.22	2	1	1385	1385	694
Vaginal hysterectomy	352	1.63	0.10	1	1	575	352	352
D & C	1126	0.28	0.04	0	0	316	0	0
							+230*	+260*
					Totals:	6113	4439	3704

* Crossmatches not covered if a 90 or 95% MSBOS had been used in Milwaukee area hospitals. These units would have had to be crossmatched during or after surgery.

totally cover the needs of 90 or 95% of the patients undergoing a given procedure. Using these criteria and the data submitted by the survey of the Milwaukee hospitals, we can calculate that the number of crossmatches would have been decreased by 1,674 using a 95% MSBOS and by 2,409 units using a 90% MSBOS. All of the blood needs of the patient would have been provided. This data is summarized in Table 5. The savings would have been between $32,000 and $48,000 using this approach.

The development of preoperative crossmatch guidelines and the use of the type and screen has allowed the State University of New York Upstate Medical Center to reduce the number of crossmatches from 29,448 in 1973 to 21,528 in 1976. During this period, the number of transfusions increased from 9,689 to 10,942 and the C/T ratio decreased from 3.03 to 1.96.[4]

In order for a hospital blood bank to offer a type and screen in lieu of a crossmatch for elective surgery, it needs available personnel to completely crossmatch blood within 30 minutes, it must have the cooperation of its surgical and anesthesiology departments, and it must have an available supply of type specific blood in its bank.

All hospital transfusion committees should be encouraged to study this problem and should establish preoperative crossmatch guidelines for their institutions. They should encourage the use of type and screen in lieu of the crossmatch for those operations in which the possibility of significant blood loss is remote. If this is accomplished, there will be a large monetary saving for the community, a decrease in the number of outdated units of blood and an improved utilization and availability, all without jeopardizing the patients.

EDITOR'S NOTE: Additional data in table form are available from the authors (see footnote on title page for address).

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Perinatology

Editor: **LUIS B CURET, MD**
Professor, Department of Obstetrics and Gynecology
University of Wisconsin Center for Health Sciences
Madison General Hospital, Madison, Wisconsin

A neonatologist looks at cesarean sections

Richard D Zachman, PhD, MD
Madison, Wisconsin

EDITOR'S NOTE: With the increased cesarean section rate across the United States, it is appropriate to evaluate neonatal complications resulting from such deliveries. The following article highlights some of the neonatologist's concerns and makes a few simple and important suggestions to minimize poor outcomes.

IN THE 20TH CENTURY, there has been a significant increase in the incidence of cesarean sections. For example, at Madison General Hospital, Madison, the rate in 1970 was 6.1%; in 1974, 12.2%; and in 1977, 17.7%. The USA average increased from 5.2% in 1970 to 11.6% in 1976. Usually larger hospitals have greater increases than small hospitals. Some of this is due to regionalization resulting in referral of complicated obstetrical problems from the smaller hospitals to tertiary care centers. The trend of rising section rates is also an international phenomenon.

Many people believe that there are at least three major reasons for the increased cesarean section rate: (1) As primary cesarean section rates continue to rise, there will be an inevitable increase in the repeat cesarean rate in an atmosphere of decreased tolerance of vaginal delivery following previous cesarean sections. (2) Cesarean sections for fetal distress appear to be increasing in frequency. In the Los Angeles County Hospital there were ten times as many patients who had undergone cesarean section for fetal distress in 1974 as in 1965. (3) There has been an increased tendency to perform an elective cesarean section for breech presentation. Again, the data in Los Angeles County in 1974 showed there were 30 times more cesarean sections for breech presentations than there were in 1965.

At Madison General Hospital where there is an active Perinatal Program, the indications for cesarean section have remained about the same from 1974 to 1978. These indications are listed in Table 1. Of note is that repeat cesarean sections and cesarean sections for breech deliveries account for 50% of the cesarean sections. This is comparable to the Los Angeles County data despite the fact that the populations of the two institutions are probably quite different. There was little change in the percent of C/Ss done for each of the categories over the five-year period at Madison General.

The neonate is potentially at risk for undesirable sequelae when born by cesarean section. One of these problems is asphyxia. The average 1-minute APGAR for the repeat cesarean was 7.4 This compared favorably with the 1-minute APGAR for normal vaginal deliveries at our institution and suggests that the general anesthesia used has not contributed significantly to asphyxia. However, lower average APGAR scores were found for those babies delivered by cesarean section for fetal distress and other reasons (includes previa, abruptio, maternal rupture of membranes and fever, severe toxemics, etc). The average 5-minute APGAR for all categories was 8.5 or greater. The reason for cesarean section has some effect on the incidence of asphyxia in our neonatal population. For the 50% of cesarean section deliveries not done for repeat or breech indications; *ie,* nonprogression, CPD, fetal distress, and other; one out of five was asphyxiated as evidenced by an APGAR score of 0-3 at one minute (Table 1). Possible reasons for this include intrapartum fetal hypoxia as a result of complications of the labor that led to the cesarean section, anesthesia, poor resuscitation, or other unknown reasons.

There are other neonatal sequelae of cesarean section besides asphyxia (Table 2). During a vaginal delivery up to one-third of fetal lung fluid is expressed out the trachea by thoracic compression. The remainder is then taken up by the perivascular lymphatics and pulmonary capillaries. A cesarean eliminates the vaginal squeeze on the neonatal chest and therefore allows more fluid to remain in the alveolar spaces. While this extra fluid is being reabsorbed after birth, there is frequently some transient effect on the pulmonary mechanics of the neonate. The lung weight/body weight ratio is higher in cesarean babies. The crying vital capacity is less, and thoracic gas volume is less when cesarean newborns are compared to vaginal deliveries. X-rays

From the Department of Pediatrics, University of Wisconsin Medical Scool, Madison. Publication support provided by the Wisconsin Perinatal Center, Southcentral Region, Madison. Reprint requests to: Wisconsin Perinatal Center, Southcentral Region, 202 South Park St, Madison, Wis 53715. Copyright 1979 by the State Medical Society of Wisconsin.

Table 1—Reasons for cesarean section

Indication	Percent of each: LA County[1] 1974	Percent of each: Madison General Hospital[2] (MGH) 1974	Percent of each: Madison General Hospital[2] (MGH) 1978	MGH—1978 data at 1 minute: Average APGAR	MGH—1978 data at 1 minute: % Asphyxia (0-3) APGAR
Repeat	33	39.0	38.0	7.4*‡	7
Breech	21	9.5	10.0	6.7	7
Nonprogression	16	17.0	16.0	8.0	18
CPD	4	9.5	8.0	7.0	14
Fetal distress	10	12.0	11.5	5.4‡	24
Other	16	13.0	16.5	6.0‡	20

[1]*Am J Obstet Gynecol* 125:798 (1976)
[2]Birthrooms record—MGH

*Average APGAR at 1 minute for normal vaginal delivery at MGH was 7.6 during same time period
‡Probably statistically different

demonstrate fluid in the lateral fissure and an engorged perihilar vascular pattern. The infant with wet lung disease is frequently tachypneic and requires 30-35% O_2 for the first one to two days of life. Usually, however, this is a benign disease and recovery almost always occurs. Another possible neonatal sequelae of C/S is the effect of delayed cord clamping and level at which the neonate is held after delivery on the infant's blood volume. In a study of blood volume in infants of cesarean sections (*Am J Obstet Gynecol* 117:351, 1973), it was found that babies who were laid at the level of the placenta and had their cords immediately clamped had a blood volume of 97 ml/kg. If the cord clamping was delayed three minutes and the infant placed 15 cm below the placenta, the blood volume of the neonate was an excessive 106 ml/kg. On the other hand, if the cord clamping was delayed three minutes and the infant was held 15 cm above the placenta, the blood volume was markedly reduced to 67 ml/kg. Therefore, when doing cesarean sections, one should attempt rapid cord clamping at the level of the placenta for the benefit of the neonate.

Iatrogenic Respiratory Distress Syndrome (RDS) after elective cesarean section (C/S) is an all too frequent occurrence. RDS results from a lack of pulmonary surfactant leading to atelectasis and hypoxia in the neonate. This is a devastating disease and leads to about 15,000 neonatal deaths per year in the US alone. Several institutions have found that many of their admissions to neonatal intensive care for RDS have come from elective C/Ss. At Yale, 15% of all their neonatal RDS cases were from elective C/S or C/S not indicated. In Cleveland, 12% of all neonatal intensive care unit RDS admissions were born after elective intervention without prior evaluation of pulmonary maturation. Likewise, in Hershey, Pa, 15 of 38 RDS admissions to their neonatal unit were from C/Ss done without fetal maturity studies (L/S ratio). These authors estimated that iatrogenic RDS from cesarean sections costs in the range of ten million dollars per year in the USA (*Am J Obstet Gynecol* 125:617, 1975; *Am J Obstet Gynecol* 126:43, 1976; *JAMA* 238: 2036, 1977).

There are many possible maternal/family disadvantages to the C/S. They include: (1) increased length of hospital stay and separation from the home; (2) increased financial costs; (3) there are still maternal mortality risks [probably in the range of 1 in 2,000 cesarean sections, obviously varying on the population and the severity of the disease with pregnancy]; (4) there is still a considerable maternal morbidity with infection; (5) the mother delivering a baby by C/S frequently has psychological problems. This is not well documented in any studies, but many authors speak of the problem. There are the depressive effects of the medication, anger towards the baby as the cause for C/S, and a feeling of inadequacy and shame by the mother (*Am J Nursing*, pg 202, July 1978). In addition, the father feels left out, since his participation in the delivery was taken completely away. Therefore, unless extra effort is made in supporting the family, the parents of a C/S could have many long-lasting negative feelings. Regarding the development of mother/baby relationships, one study has shown that C/S babies scored lower on a behavior score from 24 hours to 10 days of age than vaginally delivered babies. In addition, the C/S babies demonstrated poorer sucking for four to five days than a control population of vaginal delivery babies.

Table 2—Some sequelae of cesarean section

NEONATAL PROBLEM	COMMENT
Asphyxia	Probably related to reason for section
"Wet lung"	Mild disease, recover in 36-48 hours
Blood volume	Avoid delayed cord clamping
Iatrogenic respiratory distress syndrome	Up to 15% neonatal intensive care admissions due to repeat C/Section without fetal lung maturation studies
MATERNAL/FAMILY PROBLEM	
Prolonged hospital stay and increased costs	
Maternal mortality risks	Probably still about 0.5%
Maternal infection morbidity	About 30-40%
Family loss of "controlling and participating in delivery"	

In summary, there is an increased C/S rate in most US hospitals. Factors contributing to this are the increase in repeat cesarean section, an increased number of sections being done for fetal distress as fetal monitoring becomes used more commonly, and thirdly, there is an increase in cesarean section for breech deliveries. There are several neonatal sequelae of cesarean section. The APGAR scores of repeat C/Ss were the same as vaginal deliveries in our population. However, with C/S deliveries for other causes, lower APGARS and an incidence of asphyxia (1-minute APGAR of 0-3) was alarmingly high (1 out of 5). "Wet lung," altered blood volume, and iatrogenic RDS could result from C/S deliveries. Problems with blood volume can be eliminated by immediate cord clamping while the baby is at the level of the placenta. Determination of pulmonary maturation or being sure of dates before an elective C/S could eliminate iatrogenic RDS. There is a need for increased psychological support of the C/S family. So, in all, the perinatal team must thoughtfully weigh the advantages and possible sequelae of cesarean section. In the majority of cases, cesarean is indicated and many of the neonatal/family sequelae can be eliminated by a thoughtful and skillful approach to the situation.■

Abstracts

Long-term followup of farmer's lung with and without recurrent exposures

SHELDON BRAUN, MD; G A DOPICO, MD; W G REDDIN, PhD; DAVID R NICHOLS, MD; EDWARD HORVATH, MD; HELEN A DICKIE, MD; JOHN RANKIN, MD, University of Wisconsin, Madison, Wis: *Am Rev Respir Dis* 115 (Suppl): 47, 1977.

Fifty-eight patients with farmer's lung disease were followed clinically, radiologically, and physiologically since 1956. The period between onset of disease and the last study ranged between 27 months and 33 years (mean, 14 years). When last studied the mean vital capacity (VC) was 102% of predicted with 6 of the 58 (10%) patients having less than 80% of predicted. The mean diffusing capacity (DL) was 84% of predicted with 23 of 57 (40%) patients having less than 80%; mean PaO_2 of 70 mm Hg, with 25 of 53 (47%) patients having less than 70 mm Hg. Radiologic changes compatible with interstitial pneumonitis were present in 20 of 58 (34%).

As a group, those who had continued farming (Group I) had a lower VC, higher DL, and lower PaO_2 than those who had left farming (Group II). Both groups demonstrated a higher than expected average yearly decrement in VC of 69 ml/year with a greater loss yearly in Group I than in Group II. In addition, those in Group I who had experienced 5 or more identifiable recurrences of farmer's lung disease had a lower mean percent of predicted DL than those who had less than 5 or no recurrences ($p<0.05$), but no differences in VC and PaO_2. Abnormal roentgenograms were also more common in the former group.

These data suggested that continued exposure results in a greater long-term loss of function, and that with identifiable recurrences the loss is even greater. However, continued abnormality in function may exist in spite of avoidance of exposure. ■

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AMA Interim Meeting highlights

Wisconsin was well represented at the American Medical Association's Interim Meeting last month in Chicago. Physicians from Wisconsin attending the three-day meeting were: SMS President Jules D Levin, MD, Milwaukee; SMS President-elect Darold A Treffert, MD, Fond du Lac; AMA Delegates Gerald J Derus, MD, Madison, DeLore Williams, MD, Milwaukee, Henry F Twelmeyer, MD, Wauwatosa, John K Scott, MD, Madison, and George E Collentine Jr, MD, Milwaukee; Alternate Delegates Warren H Williamson, MD, Racine, and George A Behnke, MD, Kaukauna; incoming Delegates John D Riesch, MD, Menomonee Falls, and Cornelius A Natoli, MD, LaCrosse.

At that Meeting the AMA House of Delegates:

- Reaffirmed the AMA Board of Trustee's authority to act on behalf of delegates; approved of the AMA settlement of a suit involving chiropractic in Pennsylvania; and approved continuation of a public education campaign to alert patients to the hazards of treatment based on unscientific principles.
- Cut back its ten-year commitment to comprehensive health insurance for all Americans in favor of a limited approach targeted toward covering the uninsured and providing insurance against catastrophic costs.
- Opposed the concept of mandatory second opinions or the imposition of financial penalties for not obtaining a second opinion.
- Reaffirmed a physician's right to delegate medical functions to allied personnel who work under his/her supervision, direction, and responsibility.
- Voted to "encourage" the US Dept of Agriculture to study ways to discontinue the federal tobacco price support system and offered support for state anti-smoking legislation. ■

AMA-RPS action in Chicago

The American Medical Association's Resident Physicians Section (AMA-RPS) met during the AMA Interim Meeting in Chicago to conduct workshops and skill sessions for residents and to act on several key issues facing resident physicians. Wisconsin residents were represented by Stephen Imbeau, MD, Madison; Susan Wester, MD, Madison; Lawrence Hiphshman, MD, Madison, and Lou Sagert, MD, Marshfield.

At the Democratic Assembly session December 2 the AMA-RPS Delegates: requested a study of the ramifications of a full-time RPS chairman; supported the concept of AMA input into the legislative debate on National Health Insurance; requested federal repeal of grants to tobacco growers, and explored specific steps to effect better cost control.

According to reports from various RPS state organizations, the Resident Physician Section movement is beginning to make important gains; 12 states now have resident organizations, and in the last five months eight new local housestaff associations have joined the RPS ranks. ■

Physician-patient communication program underway

A major effort to improve communications between doctors and their patients was launched last month by the SMS Commission on Public Information and the Communications Dept. The program, entitled "Partners in Good Health," contains statement stuffers, reception brochures, patient feedback questionnaires and a certificate of participation to be displayed in the reception area. The program emphasizes the fact that good health is a joint responsibility between doctor and patient and requires healthy lifestyles and preventive techniques. Orders for supplies of the brochures and questionnaires should be sent to the SMS Communications Dept, Box 1109, Madison, Wis 53701. ■

SMS-Ophthalmology successful in limiting optometric drug usage

The Assembly Committee on Health and Social Services unanimously voted November 13 that three ocular drugs — atropine, homatropine, and pilocarpine — be removed from the list of approved drugs for optometrists to use in their practices.

The committee's action came at a public hearing it held to review the administrative rules for Wisconsin's new optometric drug law. At that hearing, representatives of SMS and its Section on Ophthalmology, including Arthur Tacke, MD of Milwaukee and Thomas France, MD of Madison, gave testimony objecting to the Department of Regulation and Licensing's rules that permitted use of three ocular drugs by optometrists. Also objecting to the rule was Joseph Robinson, professor at the UW-School of Pharmacy.

Physicians statewide were mobilized during the last few weeks to inform Assembly committee members of the potential dangers of allowing optometrists to use the diagnostic drugs.

Rep Joseph Czerwinski, chairman of the Assembly committee, said if the Department refused to delete the drugs from the rule, he would recommend suspension of the rule by the Joint Committee for Review of Administrative Rules. Department sources have indicated that they will comply with the committee's recommendation and delete the drugs. ■

Milwaukee providers seek answers to rising health-care costs

Various proposals for curbing ever-rising health-care costs were examined by more than 250 physicians, hospital administrators, and other health-care professionals November 30 at a conference sponsored by the Medical Society of Milwaukee County at the Olympia Resort in Oconomowoc.

The conference provided participants with a look at the cost containment issue from a variety of perspectives, including those of consumers, employers, educators, hospitals, and physicians.

Rep Joseph Czerwinski (D-Milwaukee), chairman of the Assembly Health and Social Services Committee stated the problem of rising costs in health care can be traced to "supply and demand." Czerwinski said we should develop more incentives for consumers, such as giving free physician visits to those individuals who do not use their health insurance for costly emergency room services.

Derward Lepley Jr, MD, president-elect of the Medical Society of Milwaukee County said that a community health board should be formed to coordinate cost-effective preventive medicine programs, urge the elimination of excess health services and promote other cost-saving ideas.

Mark Tabak of the United Auto Workers (UAW) said popular consumer cost-sharing ideas would have little impact on containing costs. Increasingly the decisions affecting health-care costs are made by providers, not consumers, he said.

Physicians need to become more aware of the cost implications of their decisions according to Norman N Gill, executive director of the Citizen's Governmental Research Bureau. However, Jules D Levin, MD, president of the State Medical Society, reminded those present that America has preached that there is "no price tag on a human life." "The more we get, the more we want," he said.

The conference, sponsored in cooperation with Blue Cross and Surgical Care-Blue Shield, also included strategy sessions where participants worked on developing an implementation plan for cost-containment in Milwaukee. ■

SMS physicians thanked for site survey work

The State Medical Society's Commission on Continuing Medical Education extends its appreciation to the following physicians who have participated in site survey visits for CME accreditation during 1978: Edward F Banaszak, MD, Milwaukee; Edwin L Bemis, MD, Milwaukee; George A Berglund, MD, Milwaukee; Timothy A Correll, MD, Dodgeville; Andrew E Cyrus Jr, MD, Sheboygan; Richard W Edwards, MD, Richland Center; Chesley P Erwin, MD, Milwaukee; Robert J Fink, MD, Eau Claire; Martin Z Fruchtman, MD, Waukesha; Bradley G Garber, MD, Osseo.

Paul R Glunz, MD, Beaver Dam; Paul W Grotenhuis, MD, Rhinelander; George H Handy, MD, Madison; George C Hank, MD, Madison; William E Hein, MD, Green Bay; Robert D Heinen, MD, Chilton; Erwin O Hirsch, MD, Milwaukee; Warren J Holtey, MD, Marshfield; James T Houlihan, MD, Woodruff; Melvin F Huth, MD, Baraboo; John F Kuglitsch, MD, Fond du Lac; James M Lewis, MD, Baraboo; Joseph J Mazza, MD, Marshfield; John E McKenna, MD, Antigo; Henry R Mol, MD, Elkhorn.

Albert J Motzel Jr, MD, Waukesha; Hohn M Nelson, MD, Madison; Thomas F Nikolai, MD, Marshfield; Edwin L Overholt, MD, LaCrosse; ER Chang Ping Jr, MD, Winnebago; Guenther P Pohlmann, MD, Milwaukee; John L Raschbacher, MD, Waukesha; Richard D Sautter, MD, Marshfield; Weldon D Shelp, MD, Madison; Sigurd E Sivertson, MD, Madison; Frank A Springer, MD, Menomonie; Paul C Tracy, MD, Madison; James J Tydrich, MD, Richland Center; Philip H Utz, MD, LaCrosse; Carlton Wirthwein, MD, Milwaukee; Warren K Wright, MD, Chippewa Falls, and Edward Zupanc, MD, Monroe.

Since July 1, 1977, 33 hospitals, 22 medical specialty societies (and other health-related organizations) and one county medical society have had CME programming accredited for Category I of the Physicians Recognition Award of the AMA by the State Medical Society's accreditation program.

Many of the above physicians have assisted in ten or more surveys, and additional help is needed. Any physician interested in continuing medical education and who would like to assist in the site survey process should contact Arlene Meyer at the SMS Health Services Division in Madison (toll-free: 1-800-362-9080). ■

SMS Leadership Conference announced

The State Medical Society will be sponsoring an all-day Leadership Conference at the new UW Clinical Science Center in Madison, Saturday, February 24. See details in NEWS YOU CAN USE section of this issue. ■

An insurance package for MDs

For several months SMS Staff and Seefurth-McGiveran, under the guidance of the Committee on Economic Medicine, have been working on the details of a comprehensive insurance plan for physicians' offices. Known as the SMS Practice Protection Plan, with the Federal Insurance Company division of Chubb & Son as the carrier, the program will be available in early 1979.

The original plan had called for announcement of the Plan last December, supplemented by Office Umbrella and Personal Umbrella policies for which quotations had been received from AETNA Insurance Company and accepted by the Council. The delay has been caused by AETNA's sudden and unexplained refusal to proceed with the program. In the light of such action SMS is inclined to view AETNA's proposed reentry into the professional liability field in Wisconsin with some skepticism. ■

Uniform claim form in demand

SMS Services Inc reports that more than 1.5 million new uniform claim forms already have been sold and distributed. Physicians and clinics are ordering so many of the forms, in fact, that SMS Services Inc has all it can do to keep up with the demand! Surgical Care-Blue Shield has informed SMS that it will endorse the new form. All other insurance carriers in Wisconsin continue to accept the uniform claim form, but do not endorse it. ■

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of Nov 14, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BROWN

Hinckley, James A, 1551 Dousman St, Green Bay 54303 (1945, Regular, Orthopedic Surgery, Certified)
Marlett, Myron M, 2021 S Webster Ave, Green Bay 54301 (1945, Regular, Urology, Certified)
Shaffer, Richard L, 1061 W Mason St, Green Bay 54304 (1946, Regular, Obstetrics and Gynecology, Certified)
Wanamaker, William M, 704 S Webster Ave, Green Bay 54301 (1938, Regular, Neurology/Psychiatry, Certified- P)

DANE

Atkinson, Benjamin W, 1 S Park St, Madison 53715 (1936, Regular, Family Physician)
Crawford, W C III, 521 Northport Dr, Madison 53704 (1944, Regular, Internal Medicine/Emergency Medicine)
Erbach, Thomas J, 1879 E Washington Ave, Madison 53704 (1948, Resident, Otorhinolaryngology)
Finlay, Jonathan L, 606 Blue Ridge Parkway, Madison 53705 (1948, Resident, Pediatrics/Hematology)
Harvey, Richard F, 1300 University Ave, Madison 53706 (1930, Regular, Physical Medicine and Rehabilitation/Radiology, Certified-PM)
Hipshman, Laurence, 5404 Mathews, Middleton 53562 (1951, Resident, Neurology)
Langer, Leonard O Jr, 3302 Leyton Lane, Madison 53713 (1928, Regular, Radiology, Certified-R)
Moorthy, Aroor V, 2500 Overlook Terrace, Madison 53705 (1945, Regular, Nephrology/Internal Medicine, Certified-IM)
Pulver, Nathaniel J, 1 S Park St, Madison 53715 (1921, Regular, Pediatrics, Certified-PD)
Stone, Dennis W, 36 S Brooks St, Madison 53715 (1947, Regular, Pathology, Certified-PTH)
Zwiebel, William J, 1300 University Ave, Madison 53706 (1944, Regular, Radiology, Certified)

LACROSSE

Amundsen, Duane G, 815 S 10th St, LaCrosse 54601 (1939, Regular, General Surgery, Certified)
Fitzpatrick, Richard, DO, 114 9th Ave, South, Onalaska 54650 (1948, Regular, General Practice)
Thompson, Teddy L, 709 S 10th St, LaCrosse 54601 (1947, Regular, Family Physician, Certified)

PORTAGE

Barkow, Kathleen M, 3280 Thompson Ct, Stevens Point 54481 (1949, Regular, Pediatrics)

RACINE

Linstroth, John W, 1131 Sherwood Lane, Caledonia 53108 (1949, Regular, Emergency Medicine/Internal Medicine)
Odders, Richard N, 4010 Washington Ave, Racine 53405 (1947, Regular, Internal Medicine)

SHEBOYGAN

Brauer, Warren A, 528 Evergreen Parkway, Sheboygan 53081 (1949, Regular, Family Physician)
Helminiak, Robert A, 1011 N 8th St, Sheboygan 53081 (1948, Regular, Internal Medicine, Certified)
Hizon, Josefina L, 607 N 8th St, Sheboygan 53081 (1933, Regular, Psychiatry)
Jackson, Thomas W, 107 Division St, Plymouth 53073 (1950, Regular, General Practice)
Louden, Richard K, 1720 N 8th St, Sheboygan 53081 (1945, Regular, Otorhinolaryngology/Plastic Surgery, Certified-OTO)
Marsho, Patrick R, 531 N 7th St, Sheboygan 53081 (1948, Regular, Family Physician)
Sellinger, D Scott, 1226 N 8th St, Sheboygan 53081 (1947, Regular, Orthopedic Surgery)

WASHINGTON

Moths, Robert W, 2500 N Mayfair Rd, Milwaukee 53226 (1948, Regular, Radiology)

WINNEBAGO

Allen, Herbert M, 111 E Wisconsin Ave, Neenah 54956 (1944, Regular, Psychiatry)
Duvall, Joseph M, 411 Lincoln St, Neenah 54956 (1948, Regular, Dermatology)
Swanson, John D, 411 Lincoln St, Neenah 54956 (1946, Regular, Pediatrics)
Syverud, James C, 411 Lincoln St, Neenah 54956 (1942, Regular, Ophthalmology/Emergency Medicine)

WOOD

Sagert, Louis A, 1000 N Oak Ave, Marshfield 54449 (1946, Resident, Internal Medicine)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Haug, Gary A, APO New York, to 9645 Manitou Park Dr, US Army Hospital, Minocqua 54548
Joachim, Frederick G, Madison, to 65 S Port Royal Dr, Hilton Head Island, SC 29928

EAU CLAIRE-DUNN-PEPIN

Lockrem, John D, Eau Claire, to 5004 E St Charles Ave, St Charles, LA 70605

GREEN

Cline, Ross L III, Madison, to Rte 3, Box 45 B, Monroe 53566

JEFFERSON

Netzow, Earl J, Cedar Grove, to High Hawmock Villa Dr, Seabrook Island, Johns Island, SC 29455

MANITOWOC

Radl, Cyril J, Manitowoc, to 7350 Via Paseo Del Sur, Scottsdale, AZ 85258

MARATHON

Akhtar, Syed Hasan, Wausau, to Archer Memorial Clinic, Prestonsburg, KY 41653

MILWAUKEE

Biek, Richard W, Milwaukee, to Veterans Home, King 54946
Dillon, Michael E, Burlington, to 523 Aber St, Waterford 53185
Knavel, James L, Milwaukee to 101 Broad St, Lake Geneva 53147
O'Brien, Marilyn J, Arlington Heights, IL, to 10402 Danica Court, Rockford, IL 61111

WASHINGTON

Bauer, Carroll A, Elm Grove, to CMSR Box 34, Phillips 54555

Wex, Thomas E, Quantico, VA, to 279 South 17th Ave, West Bend 53095

WAUKESHA

Logan, Michael J, Delafield, to 34810 Pabst Rd, Oconomowoc 53066

WINNEBAGO

Vincent, Robert A, Monroe, to 1209 S Commercial St, Neenah 54956

DEATHS

Simones, John J, LaCrosse County, Sept 18, 1978
Scherping, Walter H, Manitowoc County, Oct 13, 1978
Levine, Abram, Milwaukee County, Oct 19, 1978 ■

Obituaries

◈County, State, AMA Members

◈ **Richard E Housner, MD,** 69, Richland Center, died Sept 24, 1978 in San Francisco, Calif. Born Feb 11, 1909 in Cazenovia, Doctor Housner graduated from Marquette University School of Medicine in 1934. He had practiced medicine in Richland Center since 1937 and was one of the founders of the Richland Medical Center, Ltd. Surviving are one daughter, Mrs Jeanette Papodopolis, Allisonburg, Wash; and two sons, David, Sun Prairie, and Robert of Edgerton.

Forrest A Fike, MD, 85, Madison, died Sept 29, 1978 in Reedsburg. Born Dec 9, 1892 in Findlay, Ohio, Doctor Fike graduated from Northwestern University School of Medicine, Evanston, Ill, in 1921. He practiced medicine in Reedsburg from 1922 - 1941, then moved to Madison and retired in 1941. He was a World War I veteran. Surviving are his widow, Paula; three sons, David, Washington, DC; Phillip, Birmingham, Mich; and Thomas of Norfolk, Va.

◈ **Milan G Helmbrecht, MD,** 76, Elkhorn physician since 1936, died Oct 7, 1978 in Elkhorn. Born Sept 11, 1902 in Dodge Center, Minn, Doctor Helmbrecht graduated from the University of Wisconsin Medical School, Madison, in 1934. He served in the United States Navy during World War II. Surviving are his widow, Florence; a son, Dr Leon, Pomona, Calif; and a daughter, Mrs Marcia Phyillaier, Wheaton, Md.

◈ **Douglas E Thomson, MD,** 34, Chippewa Falls, died Oct 9, 1978 in Chippewa Falls. Born June 10, 1944 in Superior, Doctor Thomson graduated from the University of Wisconsin Medical School, Madison, in 1970. He served in Vietnam from 1971 - 1973 and had been associated with Radiologists, Ltd, Eau Claire since 1976. Surviving is his widow, Andrea, Chippewa Falls.

◈ **Walter H Scherping, MD,** 81, Manitowoc, died Oct 13, 1978 in Manitowoc. Born July 15, 1897 in Saginaw, Mich, Doctor Scherping graduated from Northwestern University Medical School in 1928. He served in the United States Army during World War I and was the medical superintendent of Municipal Contagious Hospital, Chicago, prior to moving to Manitowoc in 1935. He retired from medical practice in 1976. Surviving are his widow, Ruth; two daughters, Mrs Hayden (Mary) Glatte, Medford, Ore; Mrs Mark (Jean) Mueller, Salt Lake City, Utah; and a son, James of Chicago, Ill.

Robert Emmett Terry, MD, 82, Cuba City, died Oct 13, 1978 in Dubuque. Born Apr 9, 1896 in Baraboo, Doctor Terry graduated from St Louis University School of Medicine, Missouri, in 1924. He was a general practitioner in Cuba City from 1927 - 1968 when he moved to New Mexico. He was a World War I veteran. Surviving are his widow, Loretta; three sons, Robert E, Albuquerque, NM; William, Milwaukee; John, Adams, Wis; and a daughter, Mrs William (Mary) Quinn of Dubuque, Ia.

◈ **Abram Levine, MD,** 72, Whitefish Bay, died Oct 19, 1978 in Milwaukee. Born Jan 1, 1906 in New York City, Doctor Levine graduated from Marquette University School of Medicine in 1928. Doctor Levine had been a member of the medical staffs of Deaconess Hospital, Trinity Hospital, and medical director of the Ladish Co. He also had been director of employe health and director of the Masonic Diagnostic and Treatment Center at Deaconess Hospital. He retired in 1975. Surviving are his widow, Sylvia, and a daughter, Joan of Whitefish Bay.

◈ **George D McAfee, MD,** 63, Eau Claire, died Nov 6, 1978 in Eau Claire. Born May 7, 1915 in Schofield Barracks, Hawaii, Doctor McAfee graduated from George Washington University School of Medicine in 1941. He served in the United States Army during World War II. Doctor McAfee was a diplomate of the American Board of Dermatology and Syphilology and also served on the National Board of Medical Examiners. Surviving are his widow; three daughters, Mrs Mary Fitz, Eau Claire; Joan, Fort Collins, Colo; and Dena of Portage; and one granddaughter, Alison Elizabeth Fitz.

Elizabeth Morton, MD, 76, former resident of Fox Point, died Nov 21, 1978 in LaGuna Hills, Calif. Born in 1902 in Toronto, Canada, Doctor Morton graduated from the University of Toronto. She did postgraduate work at the Mayo Clinic in surgical pathology. She accompanied her husband, Dr S A Morton to Beirut, Lebanon in 1963, which was their home for many years. Surviving are her husband; a daughter, Mary, Chicago, and a son, James of St Paul, Minn.

Gerald Anderson Fostvedt, MD, 66, Claremont, Calif, died Nov 24, 1978 in Pomona Valley, Calif. Born Mar 8, 1912 in Chetek, Doctor Fostvedt graduated from Rush Medical College, Chicago, in 1942. He practiced medicine in Barron from 1946 - 1955 before moving to California. Doctor Fostvedt served in the United States Naval Medical Corps from 1946 - 1955. Surviving are his widow, Margaret; a daughter, Andrea; and two sons, Karsten and Craig.

◈ **Edward A Backus, MD,** 69, Milwaukee, died Nov 26, 1978 in Milwaukee. Born Jan 28, 1909 in Milwaukee, Doctor Backus graduated from Marquette University School of Medicine in 1934. He served in the United States Air Force from 1942 - 1946 as a flight surgeon. Surviving is a sister, Mavis Markworth. ■

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WPS

report

for Wisconsin Physicians

Volume VIII, Number 1 January 1979

Notification of Physician's Status

WPS identifies physicians for fee-for-service claim payments on the basis of the physician's five-digit "provider number" assigned by WPS. If the physician's five-digit number is incorrect or missing from the claim form submitted, reimbursement may not be made directly to the physician or clinic. Therefore, the correct five-digit provider number should always be included on the form.

Because WPS attempts to reimburse the physician directly whenever possible, it is very important that WPS be notified of any change in a physician's status--whether he or she joins, leaves, or retires from a practice. Lack of prompt notification may result in payments being unnecessarily delayed or sent to an incorrect location.

If a physician begins practice in Wisconsin and wishes to obtain a WPS provider number, he or she must supply the following information:

1. Name
2. Address
3. Wisconsin Medical License Number
4. Specialty
5. Is the physician board certified or eligible?
6. Social Security Number
7. Is this the physician's first practice, or, if not, where has the physician practiced before and with whom (group, clinic, partnership)?
8. Status of outstanding accounts and whether accounts are associated with a clinic, group, or partnership.
9. Tax Identification Number if in a corporation
10. Authorization to Pay Agreement must be signed by each physician if payment is to be made to a clinic, group, or partnership (including Service Corporation). Forms are available upon request (see address below).

This information must also be supplied if a physician joins an existing clinic, physician group or partnership. A WPS provider number is necessary whenever service to WPS policyholders and WPS-administered Medicare Part B beneficiaries are provided in order for direct reimbursement to be made.

The request for a provider number must be in writing and should be mailed to:

Central Provider Code Unit
P.O. Box 1787
Madison, WI 53701
Attention: Mrs. Johnson, CPCU

If the request is sent to any other post office box, processing may be delayed significantly. If the physician does not receive a provider number within ten (10) working days from the date of mailing, Mrs. Johnson should be contacted at (608) 221-4711 extension 420. Mrs. Johnson may also be called if any clarification is desired regarding the above information.

If a doctor leaves or retires from practice, Mrs. Johnson should be notified in writing at the above address. Also, the same procedure is used if a physician leaves the group or clinic. Finally, physicians should notify the Central Provider Code Unit of any change in their specialty or certification status.

WPS makes every effort to reimburse physicians directly for their services as promptly as possible, and following these procedures will enable this to be accomplished with maximum efficiency. Thank you, for helping us help you.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

***Report** is a service to the physicians of Wisconsin.*

and their Medical Assistants

WPS Major Medical Coverage

Undoubtedly your office has received the following statement on a WPS Provider Explanation of Benefits:

74--These charges should be submitted to WPS by the patient on a Major Medical Claim Form after the deductible has been met.

Since this statement is the most common denial of benefits on behalf of a WPS policyholder, a brief explanation of WPS Major Medical endorsements may be of assistance.

Many WPS group health insurance policies contain both basic and Major Medical coverage. Most basic coverage reimburses basic medical services such as surgery or in-hospital medical treatment up to a dollar figure for any specific illness or condition. Major Medical coverage reimburses those services up to another dollar figure after basic coverage has been exhausted. In either case, basic coverage and Major Medical reimbursement is limited to usual, customary and reasonable charges. In addition, Major Medical coverage pays for doctor's office calls, drugs, nursing care, medical supplies and services, and other services or medical items not generally payable under the basic coverage.

Two features of Major Medical coverage must be emphasized: deductible and co-insurance. A deductible is a fixed dollar amount for which the policyholder is responsible for covered health care costs before the insurance begins to pay the covered benefits of the remaining costs. For example, if the Major Medical deductible is $50.00 per calendar year (they vary), statements for $50.00 in covered charges for the patient during that calendar year must be submitted before WPS reimbursement can begin. Deductibles for family coverage usually apply to no more than three family members per calendar year.

Co-insurance is an arrangement by which the policyholder pays a specific, continuing portion of the cost of his or her medical care. For example, if the Major Medical co-insurance rate is twenty percent, WPS will pay eighty percent of covered charges after the deductible has been fulfilled up to the maximum amount payable for a specific illness or condition while the policyholder is responsible for twenty percent.

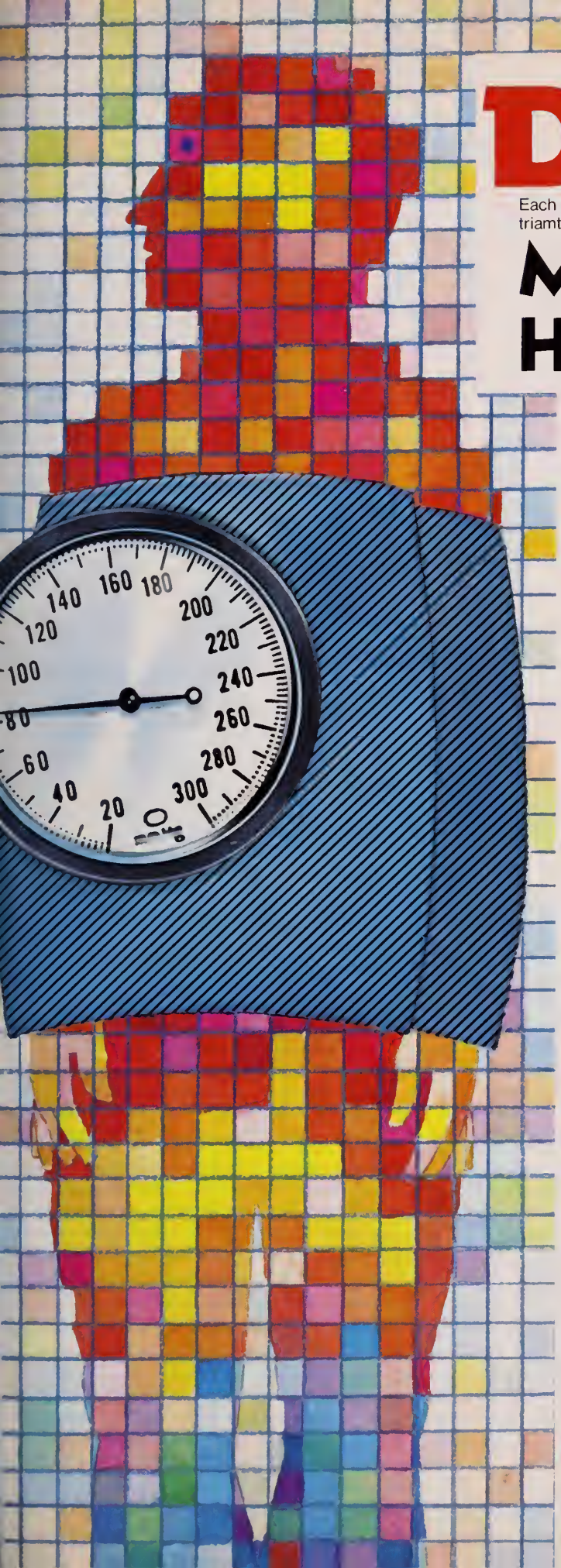
Claims for services covered under Major Medical endorsements must be submitted on a special Major Medical Claim Form along with the appropriate itemized bills. It is the policyholder's responsibility to complete and send the form to WPS, and WPS reimburses the policyholder directly. The policyholder may obtain Major Medical Claim Forms, with instructions for completing them, from:

WPS
Inquiry Services
P.O. Box 8190
Madison, WI 53708

or, in many cases, from his or her place of employment. Claims may be submitted by the policyholder whenever covered services occur or may be submitted at regular intervals.

A policyholder may discover the details of the specific Major Medical endorsement by reading his or her policy, contacting the fringe benefit officer at the place of employment, or by contacting WPS Inquiry Services at the above address or by telephone (608-221-4711).

WPS notifies both the physician's office and the policyholder by means of the code 74 statement whenever services are not covered under basic benefits but are covered under Major Medical. Therefore, when the policyholder secures itemized bills from the physician's office for the appropriate services named under the code 74 statement, a Major Medical Claim may be submitted, with WPS' reimbursement to follow after the deductible has been fulfilled. The WPS Major Medical endorsements are designed, not only to provide coverage for catastrophic illness, but also, through the deductible and co-insurance mechanism, to increase the patient's responsibility for health care spending and thereby encourage judicious health care expenditures.



Dyazide®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Makes Sense in Hypertension*

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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When painful spasm
is the presenting
symptom...

in functional G.I. disorders*

Bentyl®

(dicyclomine hydrochloride USP)

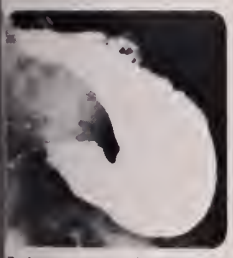
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

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Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INOICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULO BE NOTEO AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMOOICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMOOIC ORUGS AIO IN THE HEALING OF A PEPTIC ULCER, OECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective:
May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).
THESE FUNCTIONAL OISOROERS ARE OFTEN RELIEVEO BY VARYING COMBINATIONS OF SEOATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy, hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension, hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. AOVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness, insomnia; nausea, vomiting; impotence, suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. OOSAGE ANO AOMINISTRATION Oosage must be adjusted to individual patient's needs.
Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*. 1 capsule or teaspoonful syrup three or four times daily. *Infants*. ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*: 1 tablet three or four times daily. Bentyl Injection. *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1976

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Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U S A

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/ Clinical Practice." ■

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Eli Dessloch, MD* and **Thomas Farrell, MD*** of Prairie du Chien recently were honored on "Appreciation Day" by the city of Prairie du Chien and Crawford County. Doctor Dessloch established his medical practice in Prairie du Chien in 1939 and played an instrumental role in the development of Wisconsin Physicians Service and is currently chairman of the board of Wisconsin Physicians Service Insurance Corporation. Doctor Farrell opened his office for medical practice in 1935 and in 1957 brought the first group clinic practice to Prairie du Chien. The two physicians, who recently retired, had a combined total of 82 years in medical practice.

Jacob Lemann, MD,* director of the Clinical Research Center of the Medical College of Wisconsin, was recipient of the Milwaukee Academy of Medicine's "1978 Distinguished Physician Award." Doctor Lemann is also chief of the Nephrology Section at the Medical College and has become one of the country's leading experts and investigators of Renal Calculi Formation. He joined the faculty of MCW in 1963 as an assistant professor of medicine and chief of the Renal Section.

Richard W Biek, MD* recently was appointed medical director of the Wisconsin Veterans Home in King. Doctor Biek graduated from the University of Illinois School of Medicine in 1957. From 1958-1969, Doctor Biek served as a medical superintendent in Ghana, West Africa, and then served as a public health administrator for the State of Wisconsin, Division of Health, until 1977. Prior to moving to King, he was superintendent of the Bureau of Community Health Services in Milwaukee.

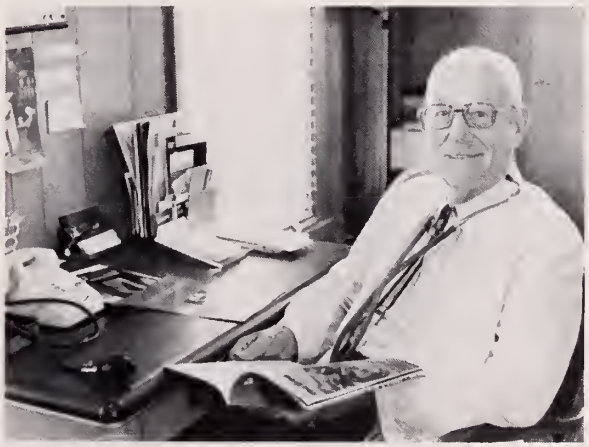
Mysore Maryayan, MD and **Manjula Maryayan, MD** recently became associated with the Tomah Veterans Administration Medical Center. A graduate of medical school in India, Doctor Manjula is in charge of Rehabilitation Medicine. She completed residencies in Physical Medicine and Rehabilitation at the University of Maryland Hospital, Baltimore, and Emory University, Atlanta, Ga. Doctor Mysore is the Chief of Medical Services and a graduate from Banglore University, India. He completed a research associationship at Emory University, a residency at Mt Sinai Hospital, Hartford, Conn, and a fellowship in pulmonary medicine at the University of Connecticut and Yale University.

Michael Dillon, MD,* a general practitioner, recently opened his office in Waterford. A graduate from Marquette University School of Medicine, Milwaukee, he served his internship at St Joseph's Hospital, Milwaukee. Doctor Dillon had been associated with the Burlington Clinic and also served as secretary-treasurer of the Memorial Hospital medical staff, Burlington.

George Hank, MD,* Madison, medical director of St Mary's Hospital Medical Center, recently retired from his medical practice of 30 years. A specialist in obstetrics-gynecology, Doctor Hank has delivered 10,000 babies in his 30 years of medical practice. He is a graduate from the University of Wisconsin Medical School, Madison. Doctor Hank helped develop the first peer review program in Dane County. The utilization review program he developed at St Mary's Hospital was the first in the state to be certified by the US Department of Health, Education, and Welfare. In his retirement he will continue to work with the peer review agencies he helped organize.

Bill Calkins, MD recently became associated with Tim Devitt, MD at the Soldiers Grove Kickapoo Valley Medical Clinic. Doctor Calkins graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at Worcester, Mass, University Hospital.

David Frens, MD, Marshfield, has joined the Marshfield Clinic medical staff in the Department of Pediatric Neurology. He received his medical degree from the University of Michigan Medical School. Before joining the Marshfield Clinic, he served as a staff pediatric neurologist with David Grant Medical Center at Travis Air Force Base in California.



EDMUND SORENSON, MD (above), Elkhorn area physician for 54 years, recently was honored by the Walworth County supervisors and Lakeland Hospital medical staff for his services to the community. Semiretired now, Doctor Sorenson still makes daily hospital rounds and maintains morning office hours. Doctor Sorenson served as president of the State Medical Society of Wisconsin in 1960-1961 and was made a Life Member in 1975.*—Photo courtesy of the *Elkhorn Independent*

Accept no substitute for your professional judgment

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

This means that the ultimate drug selection is no longer yours; its source is left to the pharmacist's discretion. You will have forfeited your right to prescribe as you see fit. Preserve your rights. Specify that you will accept no substitution.

When you accept no substitutes...

- You ensure that your patient receives exactly that product you have specified on your prescription
- You choose the quality of the product dispensed to your patient
- You can exercise the right to select a product based upon its proven therapeutic performance and to select a manufacturer that stands behind its brand name or generic product
- You can support the kinds of research programs that are vital to new drug discovery and development
- You can help sustain important physician, pharmacist and patient education services supported by innovative, research-oriented firms

For complete information on the drug substitution law effective in your state, please consult your local Pfizer Representative.

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Pfizer PHARMACEUTICALS

Robert A Worsing, MD,* Middleton, recently was appointed medical advisor for Middleton Emergency Medical Service (EMS). He graduated from the University of Minnesota School of Medicine, Minneapolis, Minn, and has had experience as a member of an ambulance service in Minneapolis. Doctor Worsing spent three years in service and as medical advisor will assist and advise the organization with EMS level training and evaluation of its operation.

Jan P DeRoos, MD,* orthopedic surgeon at the Sheboygan Clinic, recently was certified as a diplomate of the American Board of Orthopaedic Surgery Inc. Doctor DeRoos graduated from the University of Chicago Pritzker School of Medicine in 1973, served his internship and residency at the Mayo Clinic until 1977 when he joined the Sheboygan Clinic.

Don H Bodley, MD, Janesville, has joined the Janesville Orthopaedic Clinic. A graduate of the George Washington University Medical School, Washington, DC, he completed his residency at the University of Colorado School of Medicine. For three years Doctor Bodley was an orthopaedic surgeon with the United States Air Force in Colorado Springs. For the past year he has been in medical practice in Glenwood Springs, Colo.

Glenn A Dall, MD,* Wauwatosa, recently was appointed program director of The Medical College of Wisconsin's Family Practice Residency Program at Lutheran Hospital, Milwaukee. "Doctor Dall fulfills all of the requirements of this appointment, such as board certification in family practice, academic and private practice experience," said Donald J Welter, MD,* professor and chairman of the Department of Family Practice.

Gregory L Darrow, MD,* Janesville, recently joined Rocco J Vitacca, MD* of Palmer Green Medical Associates in Family Practice. Doctor Darrow graduated from Indiana University School of Medicine in 1974 and completed his residency in Family Practice at Bayfront Medical Center, St Petersburg, Fla. Prior to joining Doctor Vitacca, he practiced in Terre Haute, Ind. He is board certified by the American Board of Family Practice, and a past associate professor of family medicine at Indiana University School of Medicine, Terre Haute campus.

ROY B LARSEN, MD (right), Wausau, and former president of the State Medical Society of Wisconsin, is shown receiving the Max Fox Preceptorship Award from the University of Wisconsin Medical School at the Marathon County Medical Society meeting. Arnold Brown, MD (left), dean of the Medical School, presented the award along with a UW captain's chair. Doctor Larsen is vice-president and medical director of Employers Insurance of Wausau.—Wausau Daily Herald* photo by Rob Orcutt

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Cassandra Paula Van Nostrand, MD recently became associated with the Grantsburg Clinic, Ltd. During the past two and a half years she has been associated with the Burnett General Hospital as an emergency room physician. Doctor Van Nostrand graduated from the University of Alberta at Edmonton, Alberta, Canada, and completed her internship and residency at Alberta Hospitals. She studied pediatric cardiology in Rochester, Minnesota and at the University of Virginia hospitals, Charlottesville, Va. Doctor Van Nostrand also had additional training at St Paul-Ramsey Hospital, St Paul, Minn.

Bernard Nelson, MD, acting vice-chancellor for health sciences at the University of Wisconsin-Madison, will resign April 1 to become vice-president of the Kaiser Family Foundation, Palo Alto, Calif. Doctor Nelson was appointed acting dean of the UW Medical School in 1977 when Dean Lawrence Crowley resigned and was named acting vice-chancellor when Arnold Brown, MD was named Medical School dean last June.

John L Claude, MD,* a member of the Wilkinson Clinic, Oconomowoc, is taking a three-year leave of absence to practice overseas with the United States Army. Doctor Claude has been with the Clinic for about 25 years and will be stationed near Munich in Augsberg, Southern Bavaria, Germany. He will return to the Clinic after his enlistment.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1978

4 Madison Orthopedic Society

4 Dane County Medical Society HMP Cost Awareness Subcommittee

5 Dane County Medical Society Board of Trustees

7 WisPRO Review and Foundation

8 SMS Physicians Alliance Commission

9 Negotiation Seminar

10 Negotiation Seminar

11 Women's Health Issues Conference Planning Committee

13 SMS Committee on Safe Transportation

13 SMS Commission on Mediation and Professional Ethics

14 SMS Commission on Public Information

19 WisPRO Review Coordinator Conference

21 Ancillary Service Review Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

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M Z Khatib, MD recently opened his medical practice in Bloomer. He completed his residency in internal medicine at the New Jersey Medical School. His office is located in the Bloomer Hospital and Skilled Nursing Facility.

Ghodsi Daneshbod-Skibba, MD has joined the medical staff of the Columbus Clinic in the Department of Pediatrics. A native of Iran, Doctor Daneshbod-Skibba was an associate professor in pediatrics and hematology consultant at Tehran University. In this country, she interned at the University of Tennessee, John Gaston Hospital, Memphis, and residency was completed at the University of Virginia Hospital, Charlottesville, Va. Prior to joining the Columbus Clinic, she had been associated with the Children's Hospital, University of Wisconsin-Madison for two and one-half years.

Jack M Lockhart, MD,* specialist in rheumatology with the Gundersen Clinic, LaCrosse, recently spoke on the topic, "Arthritis - How to Live with It?", at Memorial Hospital in Prairie du Chien. Doctor Lockhart had been an instructor of medicine at the University of Minnesota Hospitals, Minneapolis, prior to joining the Gundersen Clinic in 1977.

Bruce Wineman, DO, Spencer, has joined the Marshfield Clinic medical staff in the Department of Obstetrics and Gynecology. A graduate of the Chicago College of Osteopathic Medicine, he served an internship at University of Chicago Hospitals and Clinics, then completed residency training at Chicago's Michael Reese Hospital Medical Center.

K M Narasimhan, MD,* Sparta, recently joined the medical staff of St Joseph's Memorial Hospital in Hillsboro. He is associated with the Sparta Clinic and also is on the medical staff of St Mary's Hospital, Sparta. He is certified by the American Board of Surgery and is a fellow of the International College of Surgeons. Doctor Narasimhan served his residency at St Francis Hospital, Pittsburgh, Pa, and Good Samaritan Hospital in Cincinnati, Ohio.

Mark Swanson, MD, Marshfield, has joined the medical staff of the Marshfield Clinic in the Department of Surgery. A native of Kansas, Doctor Swanson graduated from the University of Kansas School of Medicine.

Robert Lout, MD, Stanley, recently became affiliated with the Stanley Medical Center and the medical staff of Victory Memorial Hospital. Doctor Lout graduated from Georgetown University School of Medicine, Washington, DC. He served his internship and residency at St Elizabeth's Hospital in Boston. He also served for two years in the National Health Service Corps at Walhalla, ND. Doctor Lout completed a senior medical residency in internal medicine at the University of Massachusetts Medical Center in Worcester. ■

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Wisconsin Section of the American College of Obstetricians-Gynecologists recently named Joseph B Durst, MD,* LaCrosse as its chairman. Doctor Durst, an obstetrician-gynecologist at Skemp-Grandview Clinic, will serve a three-year term. He is a graduate of Marquette University School of Medicine.

The Wausau Medical Center recently reelected Thomas A Starkey, MD* as president. Doctor Starkey has been with the Medical Center since 1970. Dr Edgar B Koschmann* was reelected vice-president and the new secretary-treasurer is Dr Gerald H Schroeder.* Doctors Koschmann and Robert C Kaupie* were reelected to three-year terms on the group's board of directors. Doctor Kaupie joined the Center in July 1972 and also was chosen to serve on the group's executive committee.

Edgewood College president, Sister Alice O'Rourke, recently announced the appointment of Linda A Simunek, RN, PhD as nursing administrator of the new proposed Department of Nursing. Doctor Simunek has been a professor and dean of the College of Nursing at Lewis University, Romeoville, Ill, since 1974. Last summer Edgewood and Madison General Hospital reached an affiliation agreement whereby the college would have use of facilities at MGH's school of nursing as Edgewood's baccalaureate program develops. After the state board approves the proposed Edgewood College program, Madison General will begin to phase out its 75-year-old diploma-granting School of Nursing. The new nursing administrator was the recipient, in 1976, of the Republic of the Philippine's Presidential Award for "Outstanding Filipino Educator Overseas." In 1977 she was cited by the Cavite Association of America as "Outstanding Filipino Educator in Illinois." Doctor Simunek holds a bachelor's degree (BSN) with a major in Community Health Nursing from the University of the Philippines, a master's degree in Medical Surgical Nursing from DePaul University, and a PhD in Educational Administration from Loyola University, Chicago.

University of Wisconsin Medical School Dean Arnold L Brown, MD recently announced an agreement for a wide-ranging medical exchange program between the UW Medical School and a major Hungarian University in Budapest. The UW agreement with Semmelweis University Medical School is the first of its kind between the University of Wisconsin and an educational institution in an Eastern bloc country. Professor Milton Yatvin of the Department of Human Oncology and Radiology represented the UW Medical School at the formal signing of the agreement which took place in Budapest in late October. Professor F Antoni, president of Semmelweis University Medical School, is expected to begin the exchange program with a visit to the UW Medical School in February. ■

CME requirements for relicensure of Wisconsin physicians

At the last SMS Council meeting, a question was raised as to how physicians will know how many CME credits they have on file with the Medical Examining Board. A report from the MEB as to the lack of adequate credits is essential, so that there can be time for the physician to acquire the necessary credits for renewal of licensure.

A physician who has not completed and reported to the MEB (1400 East Washington Avenue, Madison, WI 53701) at least 30 hours of Category I CME hours, accumulated in the two-year period prior to December 31, 1979, will not have his/her 1980-1981 license to practice renewed.

Since the Council meeting, discussions have been undertaken with the MEB with the following result: The MEB encourages physicians to submit a report of CME credit hours immediately following attendance at each approved Category I course.

The MEB manually records the number of hours reported by each physician. In July 1979 the MEB will send a notice to each physician who has not yet reported 30 hours of CME credits. This letter from the MEB will inform the physician how many hours he/she is *SHORT*, and will include a warning that, unless the hours are reported, the license to practice will not be renewed. Physicians who have completed 30 hours by July 1979 will receive *NO* notice. Notices for renewal of licensure will be mailed in November 1979. ■

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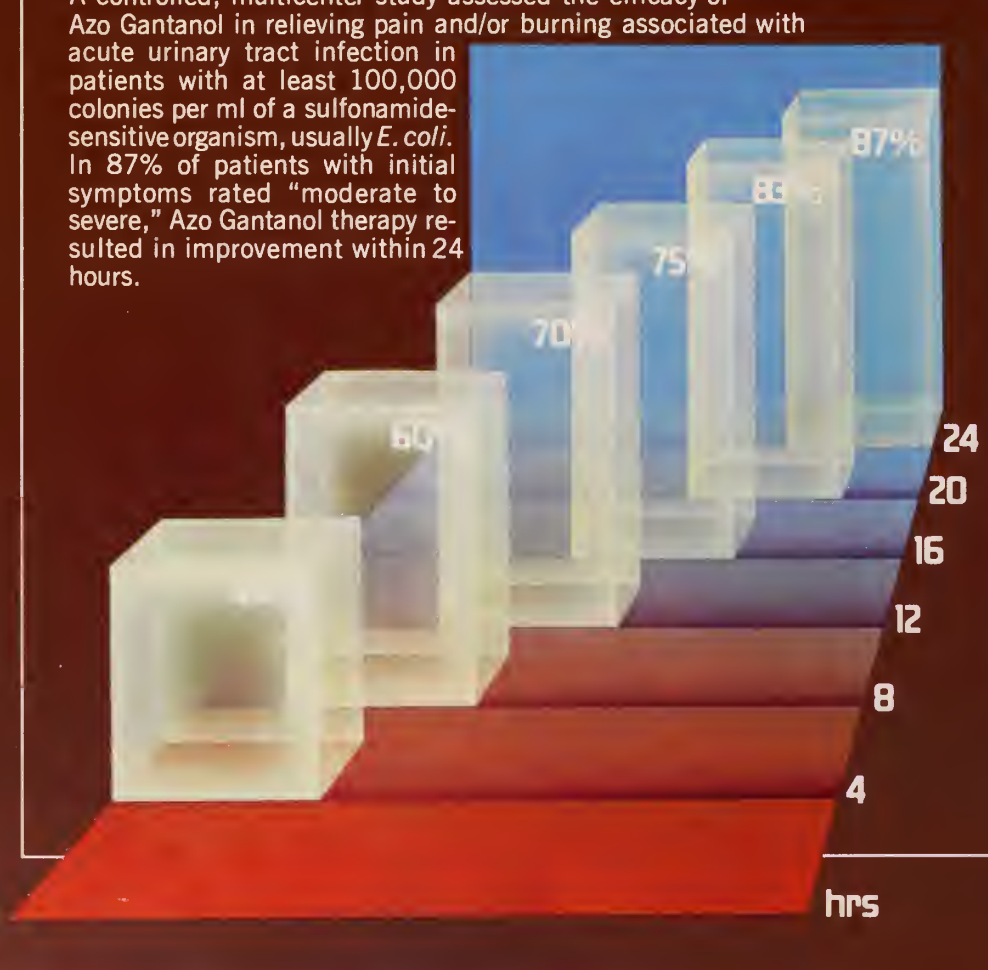

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Precautions: Use cautiously in patients paired renal or hepatic function, severe bronchial asthma; in glucose-6-phospha dehydrogenase-deficient individuals in dose-related hemolysis may occur. Main adequate fluid intake to prevent crystall stone formation.
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Physicians Exchange

WANTED: INTERNIST INterested in cardiology for part-time work (15-35 hours/week) at the Bureau of Social Security Insurance, 310 Price Place, Madison, Wis 53705. If interested please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel: 608/266-1989. 12/78, 1/79

SATELLITE POSITIONS AVAILable—Family practice opportunities available in satellite locations in farming and recreational communities with multispecialty clinic affiliation in east central Wisconsin. No investment. Complete tax-sheltered benefits and guaranteed first-year remuneration. Excellent hospital facilities. Contact Dept 456 in care of the Journal 5tfn/78

PHYSICIAN WANTED TO PERform light physicals five days per week in the Milwaukee area. Ideal job for retiring physician. Contact Mike Stough, collect, at 513/621-8728. 9tfn/77

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

PEDIATRIC, INTERNAL MEDIcine, Family Practice, Urology and ENT positions available with a multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 11-12/78;1-2/79

TWO FAMILY PRACTITIONERS urgently needed to join established group in one of the fastest growing areas of western Wisconsin. Ideal mix between farming, industry and outdoor recreational and resort area, short drive by freeway to Minneapolis and St Paul. 84-bed JAHA approved hospital and nursing home complex. Salary $40,000+, full partnership after a year, without investment. Contact Richard L Hartzell, MD, Grantsburg Clinic, Ltd, Box 169, Grantsburg, Wis 54840 (715/463-5317) or Frank Snapp, Admin, Burnett General Hospital, Grantsburg, Wis (715/463-5353). 10-12/78,1/79

OB - GYN - PEDIATRIC OPENings in 12-man group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, PO Box 178, West Bend, Wis 53095. 11tfn/78

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FAMILY PHYSICIAN: WAUSAU to join three board certified ABFP physicians. New medical office opened March 1978 and new hospital to open in 1979. Contact: R E Cadwell, MD, 212 Sturgeon Eddy Rd, Wausau, Wis 54401. Tel: 715-842-0491. 10tfn/78

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PSYCHIATRIST TO JOIN PRIvate psychiatric clinic with a family-oriented psychiatrist, psychologist, two certified social workers. Want conservative young man who enjoys work in psychiatric unit of general hospital and office practice in 40,000 pop city. Salary guaranteed up to $30,000 depending upon qualifications. Can get part ownership. 1½ hours from St. Paul-Minneapolis, good hunting, fishing, and winter sports. A A Lorenz, MD, 2125 Heights Drive, Eau Claire, Wis 54701. Tel: 715/834-3171. 2tfn/75

THREE YOUNG FAMILY PHYsicians need fourth man in college community of 80,000 in Southeastern Wisconsin. Two general hospitals with a total of 700 beds. Salary and fringe benefits first year—partnership thereafter. Contact Dept. 421 in care of the journal. 9tfn/74

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FAMILY PHYSICIAN NEEDED to join six-man group of four family physicians, one surgeon and one internist. There is an 80-bed hospital, well-equipped and major referral center 20 minutes away. Town of 9,500 with an economy based on agriculture and a small manufacturing. Located north of the crowds and south of the tourists. Excellent outdoor sport within minutes. Contact: G C Kloster, MD, 1205 O'Day St, Merrill, Wis 54452. Tel: 715/536-9511. 1-3/79

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FAMILY PRACTITIONERS: two young, board certified family physicians seek one or two board eligible or board certified family practitioners to join busy, three man group (one member leaving) in Watertown, Wisconsin, a community of 18,000, located within one hour of Madison and Milwaukee. Immediate opening. Guaranteed income. If interested, contact Watertown Family Practice Associates, 123 Hospital Drive, Watertown, Wis 53094. Tel: 414/261-8500. 6tfn/78

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FAMILY PHYSICIAN WANTED to join group of four which includes three FPs and general surgeon in lovely Cumberland, Wisconsin, situated on a clean, beautiful lake. Clinic adjacent to 47-bed hospital. Salary and benefits negotiable; partnership in one year. Contact: D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 1-2/79

PHYSICIAN WANTED—GENeral and family practice to join me in my established practice. Northeast resort area of Door County. Excellent potential. Contact: Nicholas R Wagener, MD, 802 N 3rd Ave, Sturgeon Bay, Wis 54235. 8-12/78, 1-2/79

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PHOTOGRAPHY, SKIING: NATURE photography of America, direction Charles Steinhacker, Richard Smith, noted nature photographers, conducts weekly workshops. Join a uniquely successful nature photography approach with an exhilarating outdoor experience. A splendid opportunity for creativity amidst incomparable surrounds. NPA, Telemark Lodge, Cable, Wis 715/798-3811. p1/79

Films/Audiovisual

The Seven-Minute Lesson (Acting as a Sighted Guide). Shows how a sighted person guides a blind person. Designed for use by service clubs, church groups, schools, businesses, and other groups that want to show their members the correct technique for guiding a blind person. Available for $60 purchase and $10 rental from Film Library, American Foundation for the Blind, 15 West 16th St, New York, NY 10011.

Improving communication between doctors and patients. A 16-mm color film or 3/4 inch videocassette emphasizing the need for improving communication between healthcare professionals and patients. Released by the health and safety education division of Metropolitan Life Insurance Company. Intended for viewing by professional healthcare groups, the film entitled "But, Doctor, You Said . . .," depicts three encounters between patients and healthcare professionals where misunderstandings develop because of poor verbal and nonverbal communication. A combination of photography and photo animation is used to illustrate the differences in points of view. Intended for use in the training and continuing education of physicians, nurses, and all others in the healing professions. Metropolitan recommends the film to professional schools, health centers, occupational health departments, and professional health organizations. For a descriptive brochure and order form, write to the Health and Safety Education Division, Metropolitan Life Insurance Company, One Madison Ave, New York, NY 10010.

Life Cycle. A WCCL (Wisconsin Citizens Concerned for Life) Education Fund, Inc publication, printed four times a year, by this pro-life educational organization. Deals with articles on abortion, infanticide, euthanasia, and physically handicapped, and the mentally retarded. The following MDs are on its Board of Directors Advisory Board: John J Brennan, Frederick J Hofmeister, Roland A Pattillo. Copies are available for periodical areas from: WCCL Education Fund, Inc, 4840 West Fond du Lac Ave, Milwaukee, Wis 53216.

Publications

Occupational Health Guide for Medical and Nursing Personnel. Updated, expanded. First published by the State Medical Society of Wisconsin in the 1960s. Respected throughout the United States as well as in Wisconsin by nurses and physicians in the commercial and industrial setting. This latest edition is the result of substantial change. This practical manual in a three-ring binder covers subjects ranging from "Abdominal Injuries" to "Wounds." Spaces are provided for specific written instructions by the occupational physician. It contains over 100 pages of instructional material, suggested procedures, and references to other occupational health literature. Order the ring book complete, or order only the inserts if your organization has its own ring binder.

Complete guide with ring binder $11.00*
Extra copies, without ring binder $10.00*
*plus 4% sales tax
postage is included

Checks payable to: CES Foundation, State Medical Society of Wisconsin. Order from: Committee on Occupational Health, SMS of Wisconsin, Box 1109, Madison, Wis 53701. ■

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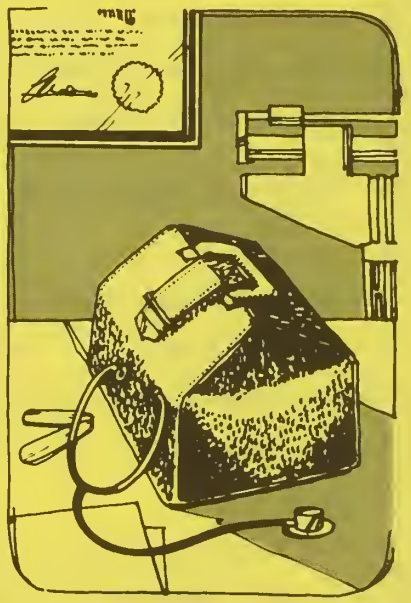
To all my patients,

Partners in Good Health

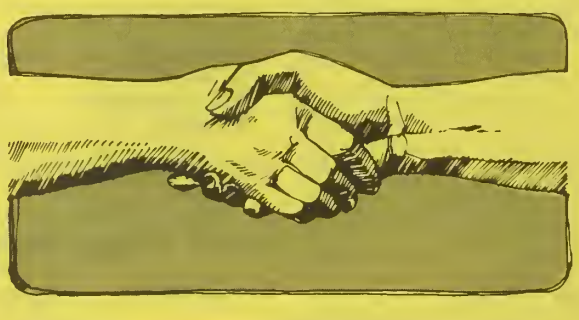


The State Medical Society of Wisconsin announces a new program designed to improve physician-patient communications and encourage greater patient feedback.

The program, entitled "Partners in Good Health," contains statement stuffers, reception area brochures, patient feedback questionaires and a certificate of participation to be displayed in the reception area.

Program brochures are available in quantity by writing to:

The Communications Department
State Medical Society of Wisconsin
P.O. Box 1109
Madison, WI 53701



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IN THE HOSPITAL

FEES FOR SERVICES

HEALTHY LIFESTYLE

Prepared and distributed
by the State Medical Society of Wisconsin

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1979 Wisconsin

Jan 26: Mendota Mental Health Institute seminar: *Working with the person with organic brain syndrome,* at the Institute, 301 Troy Drive, Madison.

Feb 1-2: Annual Financial Checkup seminar for Wisconsin physicians. Presented by First Wisconsin Bank of Eau Claire and Madison with Educational and Advisory Services Corporation of Madison and Aspen, Colorado, in conjunction with the State Medical Society of Wisconsin. At Telemark Lodge, Cable. Info: Peter Wood, SMS Services, Inc., PO Box 1109, Madison, Wis 57301; or call toll-free 1-800-362-9080.

Feb 6-8: 16th Annual Telemark Symposium and Ski Outing, sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians, at Mount Telemark, Cable. Six hours of CME credit, and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove, WI 53122.

Feb 13-14: *Great Lakes Ski-In: Winter Sports Injuries,* East Troy, sponsored by Wisconsin Chapter-American College of Emergency Physicians. Basic CPR course for spouses and children. Fee $80. Info: Contact Wis ACEP, 10201 W Lincoln Ave, Suite #304, Milwaukee, Wis 53227. Tel: 414/545-5568. Eight hours ACEP and AMA Category I credit will be applied for.

Feb 21: In-Depth Teaching Program, Methodist Hospital, Madison.

Mar 4-6: Winter Pediatric Conference, sponsored by Marshfield Clinic Department of Pediatrics, at Powderhorn Ski Lodge, Bessemer, Mich. Info: H James Nickerson, MD, Chairman, Dept of Pediatrics, Marshfield Clinic, Marshfield, Wis 54449.

Mar 15: In-Depth Teaching Program, UW Center for Health Sciences, Madison.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835.

May 3-5: Wisconsin Chapter: American Academy of Pediatrics, Pioneer Inn, Oshkosh, Wis 54901.

May 10-12: State Medical Society of Wisconsin Annual Meeting. MECCA and Marc Plaza, Milwaukee.

May 18-19: *Strabismus Symposium*-Special diagnostic techniques during the Mid-West Orthoptic Meeting.

Annual Financial Checkup for Wisconsin Physicians

at Telemark Lodge, Cable

February 1 and 2, 1979

First Wisconsin Banks of Eau Claire and Madison have joined with Educational and Advisory Services Corporation of Madison and Aspen, Colorado, to present a specially designed program for Wisconsin physicians, in conjunction with the State Medical Society of Wisconsin.

This two-day "working vacation" is designed to assist physicians in examining their own personal financial situations in an environment free of other professional distractions. Estate Planning, new tax laws, and personal circumstances dictate the need for an annual financial checkup.

Formal classroom presentations are conducted from 8:30 until 12:00 noon on Thursday and Friday. The remainder of each day is free for informal sessions, skiing, or socializing.

Seminar fees $95 per physician and $65 per spouse attending sessions.

Registration to: Peter Wood, SMS Services Inc, PO Box 1109, Madison, Wis 53701; or call toll free 1-800-362-9080.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

University Club, 924 E Wells St, Milwaukee

1979 Meeting Dates

Feb 24: *Jerry Shields, MD,* Assistant Professor, Wills Eye Hospital, 1601 Spring Garden St, Philadelphia, Penn

Mar 27: *Peter Laibson, MD,* Professor of Ophthalmology, Head, Corneal Unit, Wills Eye Hospital, 1601 Spring Garden St, Philadelphia, Penn

Apr 24: The Management of Aphakia with Contact Lenses, *Perry Rosenthal, MD,* 33 Pond Ave, Brookline, Mass.

May 11: Drug induced Ocular Side Effects, *Frederick Fraunfelder, MD,* Professor and Chairman, Dept of Ophthalmology, University of Arkansas, Little Rock, Ark

Info: Contact John L Sella, MD, 6114 West Capitol Dr, Milwaukee, Wis 53216

International Conference on Controversies in Law, Medicine, and Health Care

Feb 22-24—Canada
Hotel Vancouver, Vancouver, BC

Cosponsors: American Society of Law & Medicine and the Northwest Institute of Ethics and the Life Sciences.

Members of the legal, medical, and healthcare professions from Canada and the United States will participate in the Conference, as will representatives from both the Canadian and US governments.

Major topics to be covered:

- *Compensation for pain: thoughts for lawyers and physicians*
- *Setting healthcare standards: the role of healthcare professionals, the courts, and the government*
- *Assuring and monitoring the quality of health care: the role of the individual practitioner, the peer review group, the courts, medical licensing boards, and other governmental agencies*
- *Current controversies in patients' rights*
- *Termination of life-sustaining procedures from competent and incompetent patients and the civil and criminal implications of such actions*
- *Confidentiality and the right to die with special emphasis to pediatric problems*
- *What physicians and healthcare providers need to know about lawyers and the courts*
- *What attorneys should know about physicians and the healthcare system*

Special interest workshops: Government and patient access to medical records; child abuse; societal control of heroin addiction; and right-to-die and the living will.

Registration fee: $100 (US) for members of ASLM and NIELS, and $130 (US) for nonmembers.

Info: ASLM, Controversies in Law, Medicine, and Health Care, 454 Brookline Ave, Boston, MA 02215; or call 617/734-8316 or 206/522-9083.

1979 Wisconsin

continued

Concourse Hotel, Madison. 13 hours Category I credit. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706.

May 18-23: American Holistic Medical Association Annual Meeting, at University of Wisconsin, LaCrosse. Cosponsored by The American Society of Contemporary Medicine and Surgery. Forty hours of Category I CME credit. Info: AHMA, Route 2, Welsh Coulee, LaCrosse 54601.

June 1-2: *Medical and Surgical Corneal Disease.* North Central Regional Meeting, Eye Bank Association. Concourse Hotel, Madison. Category I credit available. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1979-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1979 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

June 22-24: 31st Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians. The Abbey Resort, Fontana, Wis. 15 hours of CME and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove 53122.

July 29-Aug 1: The Second Annual *Nuclear Cardiology for the Practicing Physician* at Playboy Club Resort, Lake Geneva, Wis. Info: Dr Jagmeet S Soin, Division of Nuclear Medicine, The Milwaukee County Medical Complex/The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5968.

1979 Neighboring

Mar 5-8: *Neurology for the Internist,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Mar 7-9: Second National Meeting of the Nurses Association of the American College of Obstetricians and Gynecologists, Conrad Hilton Hotel, Chicago.

May 14-18: American Psychiatric Association. Conrad Hilton, Chicago, Ill. Info: M Sabshin, MD, 1700 18th St, NW, Washington, DC 20009.

May 16-18: *Cardiac Auscultation and Cardiac Examination,* American College of Physicians Postgraduate

NATIONAL MEDICAL SPECIALTY SOCIETIES

1979 Meeting Dates/Sites

Jan 27-31: American College of Allergists, San Francisco. Info: F P White, 2141 14th St, Boulder, CO 80302.

Mar 22-29: American Society of Clinical Pathologists and College of American Pathologists, New Orleans. Info: J L Normoyle, 2100 W Harrison St, Chicago, Ill 60612.

Apr 2-5: American College of Surgeons, (Spring Meeting), Denver. Info: E Gerrish, MD, 55 E Erie St, Chicago, IL 60611.

Apr 26-29: Annual Meeting, American Society of Internal Medicine, New Orleans, La.

Apr 30-May 4: American Occupational Health Conference, Disneyland Hotel, Anaheim, Calif. Info: American Occupational Medical Association, Box P, 150 N Wacker Dr, Chicago, IL 60606.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

1979 Neighboring

continued

Course, Mayo Clinic, Rochester, Minn. Info: Registrar ACP, 4200 Pine St. Philadelphia, Pa 19104.

Mar 27-29: CME course: *Approaches to Clinical Problems in Gastroenterology and Hepatology*, sponsored by the University of Chicago Section of Gastroenterology and Liver Study Unit. At Center for Continuing Education, Chicago. Approved for 22 hours of Category I credit for AMA-PRA. Info: Sumner C Kraft, MD, Course Director, 950 E 59th St, Chicago, IL 60637. 1-2/79

1979 Others

Mar 24-28: American Academy of Allergy, Hilton Hotel, New Orleans, La. Info: D L McNeil, Exec Dir, 611 E Wells St, Milwaukee, Wis 53202.

Mar 26-29: American College of Emergency Physicians, Del Monte Hyatt, Monterey, Calif. Info: A Auer, Exec Dir, 3900 Capital City Blvd, Lansing, Mich 48906.

Apr 4-6: American Cancer Society, National Conference - Urologic Cancer, 1979. Los Angeles Hilton Hotel, Los Angeles, CA. Info: Urologic Cancer Conference, American Cancer Society, 777 Third Ave, New York NY 10017.

Apr 4-6: National Conference on High Blood Pressure Control, The Washington Hilton, Washington, DC. Sponsored by the National High Blood Pressure Education Program Coordinating Committee. Info: Conference Headquarters, NCHBPC, 1501 Wilson Blvd, Suite 600, Arlington, VA 22209; Tel: 703/527-4500. g9/78-2/79

Apr 26-29: American Society of Internal Medicine, New Orleans, La. Info: W R Ramsey, Exec Dir, 703 Market St, San Francisco, Calif 94103.

May 13-17: American Urological Association Annual Meeting, New York Hilton, New York. Info: R J Hannigan, Exec Sec, 4640 N Marine, Chicago, Ill 60640.

Nov 1-4: National Perinatal Association Meeting, St Louis, Mo. Contact: Convention Director, National Perinatal Association, 200 East Chestnut St, Louisville, Ky 40202. g9/78

Meetings of the American COLLEGE OF SURGEONS

CLINICAL CONGRESSES
1979: Oct 22-26—Chicago
1980: Oct 20-24—Atlanta

SPRING MEETINGS
1979: Apr 2-5—Denver
1980: Mar 24-27—Toronto

Info:
American College of Surgeons
55 Erie St East, Chicago, Ill 60611

AMERICAN SOCIETY OF INTERNAL MEDICINE

Future meetings:

Apr 26-29, 1979: Annual Meeting, New Orleans, La.

Sep 28-29, 1979: Interim Meeting, Las Vegas, Nev.

May 15-18, 1980: Annual Meeting, Washington, DC.

Sep 26-27, 1980: Interim Meeting, San Diego, Calif.

Apr 30-May 3, 1981: Annual Meeting, Denver, Colo.

18th National Conference on the Detection and Treatment of Breast Cancer

Mar 5-8, 1979 • Atlanta, Ga

Conference devoted to progress in detection and treatment of breast cancer. To feature internationally recognized authorities in the fields of radiology, surgery, pathology, obstetrics and gynecology, epidemiology, and other medical and nonmedical specialties.

Emphasis placed on team approach to cancer management and involvement of various specialties in major problem areas including: high-risk benign disease, minimal breast cancer, radiation risks, detection programs, invasive cancers, the relationship of gynecological disease and breast disease, and rehabilitation.

Sponsored by American College of Radiology. Co-sponsored by College of American Pathologists, Educational Foundation of the Society of Plastic and Reconstructive Surgery, American Academy of Family Physicians, in cooperation with American College of Obstetricians and Gynecologists.

Approved for Category I credit under the AMA continuing medical education criteria.

Further info: American College of Radiology, 6900 Wisconsin Ave, Chevy Chase, MD 20015. Tel: 301/654-6900.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

January 22—February 4, 1979

Refractory Congestive Heart Failure: The Vicious Cycle, with Kanu Chatterjee, MB, Professor of Medicine and Associate Chief of the Cardiovascular Division, School of Medicine, University of California, San Francisco; Director, Coronary Care Unit, Moffitt Hospital and Bruce H Brundage, MD, Assistant Professor of Medicine, Cardiovascular Division, School of Medicine, University of California, San Francisco; Director, Adult Cardiac Catheterization Laboratory, Moffitt Hospital. As an organization accredited for continuing medical education, the American Heart Association certifies that this continuing medical education activity meets the criteria for one credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association, and by the American Academy of Family Physicians for Prescribed credit.

February 5—February 18, 1979

Hospital Infection: Breaking Links in the Chain, with Richard H Parker, MD, Chief, Infectious Diseases, and Hospital Epidemiologist of the Veterans Administration Medical Center in Washington, DC, and Associate Professor of Medicine at the Howard University School of Medicine

Drug-Induced Tardive Dyskinesia: Reducing the Risk, with Ronald M Kobayashi, MD, Associate Clinical Professor of Neurosciences and Neurologist at the Neurology Medical Clinic at the University of California School of Medicine, San Diego.

Otitis Media in Children: Preventing Serious Complications, with Irving J Olshin, Professor of Pediatrics at Jefferson Medical College in Philadelphia.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

News You Can Use

Announcing: SMS Leadership Conference Feb 24. The State Medical Society is sponsoring an all-day Leadership Conference at the new UW Clinical Science Center in Madison, Saturday, February 24, for SMS councilors, officers, AMA delegates and alternates, county medical society and specialty section officers, and other interested members. The program will include such topics as legislation, Medicaid rules and contract, membership recruitment and retention, health planning, county medical society administration and programming, and the Federal Trade Commission and Justice Dept assault on the profession. Be sure to mark February 24 (9:30 AM to 4:00 PM) on your calendar and count on attending this important informational-educational program. Details will be coming soon.

Chiropractors survey patients. A recent survey commissioned by the Wisconsin Chiropractic Association, and written up in several Wisconsin newspapers, shows 73% of those persons surveyed feel chiropractic services should be covered by medical insurance. In addition, 12.5% of the respondents said they had been to a chiropractor within the past two years and nearly 93% of those respondents who had seen a chiropractor were satisfied with their treatment. These figures drew criticism from Jane Cloak, a research analyst at the State Bureau of Health Statistics. "Given the number of chiropractors in practice (500) and the size of the Wisconsin population (4.6 million) it sounds improbable that 12.5% of the population would have seen a chiropractor in the last couple of years. I think the results need further explanation," she said. Other findings of the survey include:

- Ninety percent of chiropractic patients were satisfied with the fees charged; 79% of the physician patients were satisfied with the fees.
- Seventy-three percent of chiropractic patients said their treatment was effective, while 90% of physician patients said they experienced effective treatment.
- Four percent of chiropractic patients said a physician referred them to chiropractors.
- Twenty percent of the respondents agreed with the statement that a "chiropractor is dangerous because he keeps people from seeking medical aid," while 65% disagreed, and 15% were unsure.

Wellness grant program underway. Donald Percy, secretary of the State Department of Health and Social Services, has announced the availability of $980,000 to fund innovative wellness and illness prevention projects. Communities, individuals, and organizations may apply for the grants. Priority will be given to those proposals which attempt to reduce the risk, incidence or effects of vascular disease, cancer, mental illness or mental retardation; maintain the natural family structure, or sustain wellness. Copies of the guidelines for the grant program may be obtained by writing: Prevention and Wellness Grant Program, Dept of Health and Social Services, Room 720, 1 West Wilson St, Madison, Wis 53702.

Title 18 profile information. A physician interested in obtaining a "profile" of his/her medical practice as recorded by either of the Title 18 (Medicare) fiscal intermediaries — WPS or Surgical Care — may do so by addressing a request in writing to: Mr Ed Helmke, Wisconsin Physicians Service, 1717 West Broadway, Madison, Wis 53713; or Surgical Care, Professional Relations-Medicare Correspondence, 401 West Michigan Ave, Milwaukee, Wis 53201. ■

STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

FEBRUARY 1979

Physician advertising . . . Physician participation in politics . . . The Carter conflict . . . The search for medical care cost containment . . . Medical-educational interaction for exceptional children . . . Acute myocardial infarction—a Northwoods experience . . . The Wisconsin Clinical Cancer Center . . . Results of unified membership poll reported

MDS

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MAR 1 - 1979

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THE ANXIETY-SPECIFIC

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Roche Products Inc.
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Front Page Update

Medical Examining Board threatens injunctions against chiropractic blood test. The Medical Examining Board has objected to a recent position taken by the Chiropractic Examining Board allowing chiropractors to draw blood for analytical and therapeutic purposes. In a letter to the Chiropractic Examining Board dated January 17, 1979, the Medical Examining Board stated that the Legislature's definition of the practice of chiropractic does not include authorization to a chiropractor to "penetrate, pierce or sever tissues of a human being." On the contrary, the Legislature has "specifically included those functions under the practice of medicine and surgery," the Board said. The Medical Examining Board has officially informed the Chiropractic Examining Board of its position and that it intends to ask the Attorney General to bring injunctions against those chiropractors who continue to draw blood after being advised of its position.

New malpractice coverage debated. The Wisconsin Insurance Commissioner has held a public hearing on a proposal to allow the Wisconsin Health Care Liability Insurance Plan (WHCLIP) to write individual policies of malpractice coverage for *employees* of physicians, hospitals, and other health practitioners or facilities. It is alleged that they need such coverage in the event their employer is not sued at the same time they are — an event which there is no evidence of ever occurring in Wisconsin. The SMS Physicians Alliance Professional Liability Committee supports the concept that employees of physicians have defense and award coverage but believes that coverage is already offered by MD policies when the two are sued together, which experience shows is certain to occur. Separate policies may be far more costly.

WPPN moving along. By March 1, 1979 the Wisconsin Physicians Planning Network hopes to have the first Physicians Task Force established in Health Systems Agency 1. If you'd like more information on the WPPN, contact Neal Neuberger at SMS Health Services Division offices. He can arrange to have a presentation on the WPPN given at your next county medical society or hospital medical staff meeting.

PA Commission objects to physician fee limit. Stating that it was done without physician consultation and that it was a "sham" upon subscribers, the SMS Physicians Alliance Commission voiced its objection to the fee increase ceiling for physician reimbursement imposed by Surgical Care/Blue Shield last July. The Commission for the past several months has been reviewing the position taken by Surgical Care/Blue Shield and concluded in a letter to company officials that the action was "little more than a public relations effort designed to appear to commit Surgical Care/Blue Shield to the 'cost containment' scenario which, in this case, seems to have been implemented at the expense of adequate subscriber protection." Commission Chairman Kenneth Viste Jr, MD, in his letter also charged that Surgical Care/Blue Shield, by unilaterally limiting physician reimbursement, had failed to comply with its subscriber contract which defines charges as the "customary, usual, and reasonable request for payment which do not exceed the general level of charges of others who render services under comparable circumstances." The action has not been communicated effectively to the subscribers who continue to believe that physicians' actual CUR charges will be paid, when in fact, they won't, Viste said. ■

STATE MEDICAL SOCIETY OF WISCONSIN

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State Medical Society of Wisconsin

STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841

Representing 4,600 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

Physician advertising

THE DECISION OF the Federal Trade Commission that advertising by physicians is legal and should be encouraged, is as repelling as it is revealing. Indeed, in the *Milwaukee Journal* of December 5, a front page editorial recommended advertising "to increase competition and (now for the magic words) lower costs." This is clearly self-serving in that this would create a new market for advertising and, thereby, an increase in revenue. Somewhat akin to a distillery offering free samples at a meeting of Alcoholics Anonymous.

The people promoting this concept have likely drawn upon superficial economic information regarding free market, supply and demand, and the favorable effect of competition on prices. This sophomoric approach overlooks the important fact that this concept, to be valid, demands that consumers have the ability to make an accurate judgment as to the quality of the product (service). Pragmatically this, of course, is impossible. Even the physician's peers have great difficulty in judging the quality of another physician's service (product). If one is to presume the consumer can make an accurate judgment as to the quality of service, the ability to do so usually requires numerous opportunities to test such quality. This is, in the majority of circumstances, impossible in that many consumers do not have a continuing need for such services; a few others have but a single opportunity to sample and evaluate a service after which they have no further need of service of any kind.

Applying this concept—the use of advertising to reduce cost—to the practice of medicine seems to be the work of mental midgets. There has, however, been a suggestion by a Nobel laureate of economics to consider removing the several limiting factors (gates), such as medical licensure and specialty Boards, on who is allowed to provide medical services. It is his opinion that if these restrictions were abolished, with the laws of economics being universal, we would increase competition and supply and, thereby, obviously reduce costs. Such economists summarily dismiss the fact that the quality of service would be adversely affected to a degree unknown in modern time, indicating that certainly those who provide the best service will flourish and those who provide poor or only fair service will fall by the wayside. Again, the flaw in this argument is that it presumes the individual consumer can judge the quality of service and has numerous opportunities to do so.

While we in medicine can do little regarding the fact that our profession is surrounded and under siege by idiots and assassins, we should implore those outside this lunatic fringe—editors, economists, bureaucrats—who wish to remold and regulate our profession to make a much greater effort to understand what is *really in the best interest of the people.* —RDS

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Wisconsin Medical Journal readership

ALTHOUGH JULY is considered a time of doldrums and vacations, it was the month selected by Health Industries Research to conduct a survey of readership of nine state medical journals. The journals chosen for survey, including Wisconsin, reflected a broad geographic cross-section of both small and large states across the country. The survey provided measurements of reading frequency, reading patterns, as well as reading levels of the various departments of each publication.

A similar study was conducted two years earlier and a comparison was made of the findings for a total of nineteen different state medical journals.

The conclusions of this survey were that state journals as a group are extremely well read. An average issue of a state journal is read by 85% of its audience, and in July the Wisconsin percentage was 89. This is a significant increase from the 79% average in the journals recorded two years before.

Other significant figures indicate that 91% of the readers want to continue receiving the *Wisconsin Medical Journal,* and that the scientific

articles are widely read. Twelve percent indicated that they read all or most of the scientific articles and 86% that they read them on a selective basis. On the same basis the percentages for the reading level of editorials was 32% and 57%, scientific abstracts and briefs 11% and 71%, SMS organizational articles 20% and 51%, and physician briefs and news highlights 26% and 61%. Only 2% indicated they did not read the scientific articles and only 5% did not read any of the editorials.

This is considered a gratifying response, both to the medical editors and staff of the *Wisconsin Medical Journal* and to the advertising sales representatives who can point out readership figures well in excess of many of the widely read national medical publications.—VSF

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Dr David Goldstein

In the Letters section of this issue of the *Journal* is a thoughtful tribute to Dr David Goldstein of Kenosha. This is written by a Kenosha colleague and recognizes Doctor Goldstein's forty years of practice and his many contributions to organized medicine.

It seems that a busy individual in any phase of life can always find time to assume additional responsibility. This has certainly been true of Doctor Goldstein. The Staff of the *Wisconsin Medical Journal* and the State Medical Society join Doctor Goldstein's Kenosha confreres in saluting him and wishing him a long and pleasant retirement.—VSF ■

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Opinion/Dialogue

Physician participation in politics

THIS YEAR'S ELECTIONS bring several facts to the fore in regard to physician participation in the elective process. Approximately one-quarter of the state physicians are members of WISPAC (Wisconsin Physicians Political Action Committee). Of this number, many are quite vocal in regard to current political issues. Unfortunately, three-quarters of the state physicians are not members of WISPAC as of this writing (Nov 28, 1978). Of the State's physicians, a significant proportion are not State Medical Society members.

These statistics can be viewed as both encouraging and discouraging. At least we now have physicians involved in candidate interviews, endorsements, and attempts to influence our elected representatives as to the merits of various health-related legislation. Unfortunately, however, we do not have anywhere near the involvement that such a highly educated group should have. As physicians, we all have the responsibility to make this a better world and I feel that participation in the political arena should no longer be shunned by physicians.

I urge all State Medical Society members to become interested in the WISPAC organization and also to help involve our nonmember friends. Only through active participation of the State Medical Society, and organizations such as WISPAC, are we going to have an impact on the vital legislation that occurs from year to year.

RUSSELL A QUIRK, MD, Member
Physicians Alliance Commission
State Medical Society of Wisconsin
Racine, Wisconsin

The meter is running

A REVIEW OF THE report of the Brown County Cost Containment Committee discloses 65 recommendations for holding down the cost of medical care. There are many worthwhile suggestions. These include "discourage excessive use of . . .," "curb unnecessary surgery," "discourage construction of unnecessary hospital bed space," and others in this vein. Res ipsa loquitur.

Where the report has less validity is in the area of ordering tests for seriously ill patients or emergency room trauma admissions. In these situations, under-utilization of laboratory and x-ray facilities under the guise of cost containment is a definite possibility. Here the attending physician needs all the help he can get; and should a critical admission to a general hospital be dealt with on a "watchful expectancy" basis rather than by vigorous patient management, the length of stay of the patient and the eventual outcome of his care may not be exactly in line with effective medical practice. In any event deferred diagnosis in many instances is diagnosis denied.

Physicians in general tend to regard hospital facilities as over-built or over-staffed or "containing too much fat" which in many instances proves to be a superficial judgment. Almost every hospital staffs and builds at the direct request of its medical staff's recommendations. Scarcely a hospital meeting can be attended by physicians at which their department does not request something additional from administration. Meanwhile, down in the financial offices, there are skilled negotiators fighting with suppliers over nickels on cases of toilet paper, canned peas, and sides of beef. Many doctors who cannot balance their own checkbooks seem to be instant authorities on the management of complex municipal and private hospitals.

Do not let the concept of cost containment interfere with the proper and prompt practice of medicine. If there is a tentative approach to diagnostic procedures by hospital physicians, they may indeed save on ancillary charges. But let us not forget that while we delay and defer, the daily room rate continues. The meter is running.

RAYMOND A MCCORMICK, MD
Green Bay, Wisconsin ■

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Letters

Doctor Goldstein—a tribute

DOCTOR GOLDSTEIN's announcement of his retirement from practice prompts me today to pay a tribute to him for his long and outstanding career in medicine.

Throughout the 40 years of his practice he has constantly immersed himself in many activities and duties related to organized medicine, such as President of Kenosha County Medical Society, Delegate to the State Medical Society, and his many years as a member of the Board of Directors of Wisconsin Physicians Service, the doctors' Blue Shield plan.

For more than two decades his wise counsel and guidance have helped shape and develop innovative health insurance policies at WPS, and have consequently influenced broader development of health-care financing mechanisms.

He served with distinction as a member of the Council on Medical Services and the Committee on Industrial Health.

He is, however, most widely known and remembered by his colleagues as Editorial Director of the *Wisconsin Medical Journal* from 1959 to 1971. Doctor Goldstein's professionalism and strong editorial concerns were clearly expressed in *Journal* editorials. He wrote widely on such topics as quality of medical education, the role of medicine in a changing society, and physicians' activism in political affairs. Some of his most powerful statements dealt with a concern foremost in the minds of most physicians—the physicians' responsibility to the patient.

Doctor Goldstein participated in issues of national consequence. He has served as a Director of the National Association of Blue Shield Plans, Director of the Foundation for Medical Care Evaluation, as Director of the Wisconsin Professional Standards Review Organization, and as a Board Member of the Wisconsin Hospital Rate Review Committee.

His outstanding career as a physician includes his longstanding membership in the American Academy of Family Physicians, the American Thoracic Society, the Phi Delta Epsilon Medical Fraternity and the American Heart Association.

He always has shown dedicated service in the practice of medicine in Kenosha. For his many good works, for giving of himself to so many duties, and for doing so much of the work so necessary in order that the medical professional can remain strong and viable, we wish to thank him and to pay this tribute to him today. We wish him good health and happiness.

ROMAN BILAK, MD, President
Medical Staff
St Catherine's Hospital
Kenosha, Wisconsin

Pesticide poisoning information source

PHYSICIANS ARE RECEIVING an increasing number of inquiries regarding pesticide overexposure. Poison Control Centers provide invaluable service to the medical profession by supplying immediate information on the recognition, diagnosing and treatment of those overexposed to hazardous chemicals.

An additional and little known source of a wealth of data about pesticide overexposure is the staff members of the US Environmental Protection Agency's Pesticide Branch in Chicago. Pesticide safety publications are available from the Branch including a 75 page medical treatment manual entitled "Recognition and Management of Pesticide Poisonings". This manual is composed of a chapter on each major chemical classification of pesticides. Each chapter contains a brief esction containing: 1) names of the most commonly used pesticides belonging to the group; 2) toxicology; 3) frequent signs and symptoms of overexposure, and 4) recommended treatment. Information relative to immediate diagnosis and treatment is in bold letters for quick and easy reference.

For information during emergencies telephone (312) 353-2192 between 8 am and 4:30 pm, during the week or mail inquiries to: Chief, Pesticide Branch, US Environmental Protection Agency, 230 South Dearborn Street, Chicago, Illinois 60604.

CURTIS A GOLDEN
Pesticide Program Specialist
US Environmental Protection Agency, Region V
230 South Dearborn St
Chicago, Ill 60604 ■

In Perspective

Editor: BRIAN JENSEN
Director, Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

The Carter conflict

For the first time in many years, I took the opportunity last month to listen carefully to President Carter's "State of the Union" address. To be sure, a part of my willingness to listen closely resulted from a growing personal and professional desire to hear the President's comments on health care. Also, I realize that governmental policies regarding health care moved rapidly into the national scene due in part to the "Great Society" mentality that suggests that problems such as the "health-care crisis" can be solved by massive national programs.

The philosophical conflict inherent in President Carter's speech was apparent during his repeated references to increased governmental regulation. The President wasted few words in advancing the theory that a balanced federal budget and less governmental interference in our lives was a cornerstone of his administration. He pointed with some pride to the deregulation of the airline industry as an example of one area in which government regulation has failed—or at least "deregulation" was a preferable alternative. In an attempt to insure competition (as anyone can see from recent travel pages of the Sunday edition of the *Milwaukee Journal*), deregulation has allowed airlines to compete, through lower airfares, for the travel dollar.

The President then suggested a similar approach in a proposed deregulation of the trucking industry. Both of these statements were greeted with solid applause and, we must assume, approval by the assembled members of the House and Senate.

Health care, however, was treated in a vastly different way. The concept of a national health insurance plan was promoted as a method of improving health maintenance and a quality of care which some presume is not available under the current system. (Even the television networks have learned to recognize presidential references to health care; without this recognition, I am sure that CBS would not have seen fit to quickly pan to the serious, deadpan face of Senator Kennedy during the references to NHI.)

But, should government attempts to solve this so-called health-care "dilemma" be represented by a personal debate between the incumbent and the heir apparent? Will NHI and continued and expanded regulation in the health-care field insure better or more successful care, or research, or coverage for those citizens whom everyone seems to believe "fall through the cracks" of adequate health care? I think not.

Whether one calls it the Great Society, or the New Frontier, or the New Foundation, I am suspect of grand plans born within the depths of the Washington bureaucracy. Even Wisconsin Congressman David Obey, in the NBC special "A House Divided" broadcast some weeks ago, suggested that Congress itself was often unable to solve major issues because of the enormous, and often unknown, impact of proposed plans and a corresponding fear of a conflict between what is proposd in theory and what emerges in actual application.

Because the efforts of the Physicians Alliance are channeled primarily toward state legislation, I continue to believe that the health-care dilemma needs to be resolved at the local level. This belief is a growing one; the State Medical Society along with a host of influential state legislators and consumer groups are in the process of developing Wisconsin legislation to accomplish what some believe the federal structure cannot: catastrophic health insurance plans tailored to the Wisconsin scene, insurance for those unable to obtain it, and physician involvement in the health planning process. A national system ignores problems unique to a state, community, or even a neighborhood. If this belief suggests an adherence to John C Calhoun's "states' rights" mentality, so be it.

Massive government regulation of the health-care industry does little to affect the *demand* for health care, personal attitudes toward health-care providers, or as some have suggested, improvements in health care.

Governmental intervention has been directed primarily to controlling the *supply* side of health care. One only needs to recall the certificate-of-need battles of years past to appreciate that the CON system requires approval of new services and new institutions with little or no regard for

the source of the financing of such endeavors.

The combination of these planning and regulatory controls at the local (state) level seems to beg for similar considerations at the *local* level for "filling in gaps" in the insurance area, physician supply, and reimbursement mechanisms. Other states, such as Minnesota, have embarked on this course and Wisconsin should follow.

Such an effort, if successful, could avoid the Carter conflict in health care and would establish organized medicine in Wisconsin as a contributor to a rational solution. A career bureaucrat once stated that "Government is too big and important to be left to the politicians." Given what I heard from the President, that statement seems more timely than ever.—BRIAN JENSEN. ■

IN PERSPECTIVE welcomes reader comment on political, legislative, or socio-economic concerns facing physicians.

President's Page

President: JULES D LEVIN, MD
State Medical Society of Wisconsin

The search for medical care cost containment

THE PROBLEM OF COST control in health care is so complex and so mind-boggling that it truthfully belongs in angel's no-man land.

The crux of the health care cost problem is stated simply and precisely in the introduction to the Summary Report of the National Commission on the Cost of Medical Care, published by the Commission in December 1977, and I quote: "After years of consumers wanting unlimited medical care, the government promoting growth in the production of both providers and facilities and physicians providing services based solely on quality, it is necessary to instill alternate behavior patterns for everyone."

Our guide word is therefore *CHANGE!* The consumer will have to be content with a no-frills, stripped down Pinto-type of medical service; the provider will have to sacrifice his ego and self-interest and I'm afraid to tell you what I think the government ought to do! Seriously, however, we must somehow convey to our legislators the fact that *the government IS the problem,* and not the cure. To accomplish this change, however, will require the wisdom of Solomon, the patience of Job, and the unquestioned authority of a benevolent dictator.

To paraphrase the proverb, perhaps we have too much of a good thing! How much of a good thing do we need? How much of a good thing do we want? How much of a good thing do we care to pay for?

HOW MUCH OF A GOOD THING DO WE NEED? The philosophy of medicine traditionally is that of doing everything possible without consideration of cost. For years society has been taught by lecture, precept, and the media that there is no limit on the amount of medical care available to them.

HOW MUCH OF A GOOD THING DO WE WANT? You have but to listen to any concerned and anxious relative of a critically ill patient, when he tells you to do everything possible for his dear one, for "money is no object." In America we have preached that there is no price tag on a human life.

HOW MUCH OF A GOOD THING DO WE CARE TO PAY FOR? Quality medical care the world over is expensive and will always remain so. The National Health Service in England has solved the problem handily for the British citizen: There is a limited and rather meager budget available for the health care of all. England allows 5.8% of the Gross National Product for all health care costs, compared to our current 8.4% here in America. Medicine in England is essentially acute and emergency medical care. It is much cheaper to defer surgery than to perform it.

Most Wisconsin physicians recognize the rapidly escalating health care costs as a major problem. Some six months ago, the State Medical Society convened a doctor's conference in Milwaukee, primarily to alert physicians to the growing importance of health care costs and the need for efforts at local cost containment at the point

where health decisions are really made—locally at every hospital. Since then every major hospital in the city has formalized a cost containment committee whose function it is to evaluate all possible effective ways to eliminate waste, to contain and reduce costs. Examples of the effectiveness of this activity in the past has been the elimination of obstetrical services in several of the major hospitals, consolidation of these services in other hospitals, elimination of a pediatric service in one hospital. Our current panel is an appropriate follow-up search for further cost containment in Milwaukee.

We have four basic options in facing the problem of rising health care costs: *ONE OPTION* is to invoke inflation as the criminal and throw up our hands in helplessness. Such an attitude is an immoral cop-out. Physicians are key decision makers in the use of medical and health services. While doctor's fees constitute only 6.5% of Wisconsin's Title-19 reimbursement, we can and do control access to many other categories of services, *ie* nursing homes, mental care, hospitals, pharmaceuticals, to mention a few. To further illustrate, you should know that studies here in Wisconsin have revealed that in a typical family practitioner's day, the doctor may attend 35 office patients and 9 hospital patients. In addition to generating fees for his own services, he will make decisions that will initiate expenditures for $3,000 to $5,000 per day for hospitalizations, medications, x-rays, laboratory procedures and other services to follow. How the doctor makes these decisions, the adequacy of the information upon which he bases his choice of treatment, the options for care, the frequency of service, who provides the care, the location of the type of facility for service . . . . all these are the keys to productivity, to efficiency, and ultimately to total cost.

A SECOND OPTION is to simply justify the costs. We can very properly do this by citing new technology, greater demand of consumers for more and better services, the greater availability of comprehensive insurance benefits, the increasing longevity and the decreasing morbidity and mortality tables. These are indeed genuine benefits of our present system. They are valid justifications for the fact that quality care is costly care, a fact that is recognized the world over. But neither is this answer enough by itself.

A THIRD ALTERNATIVE is to allow the federal government to make political hay out of the rising medical costs. This is precisely what is happening and what will continue to happen unless we take the facts of health and medical care directly to the people in our communities.

Our fiscally pot-bellied government is hardly in a position to call the kettle black! HEW secretary, Joseph Califano, publicly admitted that his department alone *wastes* as much as $7 billion a year on health and welfare programs. HEW's waste would have paid for all the health services for all the people of Wisconsin for two and one-half years! Our own Senator Proxmire tells how the taxpayers are fleeced by our government's ineptitude. A study of why people fall in love costs the taxpayers $84,000. A study of why prison inmates want to escape costs $27,000. A study on how long it takes to cook breakfast costs $45,000; an advertising campaign to stimulate letter writing costs $4,175,000!! That's a total of $4,231,000 for only four projects. There are literally thousands more. Those four studies wasted enough money to run the entire family practice program at the University of Wisconsin (including its residency program in four locations) for a full year! Last year, the doctors in Wisconsin voluntarily returned $5,000,000 in mistaken overpayments made by the state Medicaid program, a fact admitted, albeit quietly, by the Department of Health and Social Services. It is high time that we call for a change in the spending priorities of our state and national governments. Yet, it is not enough to point the finger and run.

THE FOURTH OPTION, and perhaps the most pragmatic one, is to develop and pursue our own initiatives against the spiraling costs of health care. The State Medical Society and its 4,500 physician members have already done a good deal in that regard.

We were prime movers and sponsors in the State's generic prescribing and dispensing laws.

We collaborated in a unique Certificate of Need law involving certain equipment in physicians offices.

We are co-participants with the Wisconsin Hospital Association in the succeeding Voluntary Effort to Contain Costs in Hospitals.

We have launched a statewide cost-conscious effort among physicians.

We recently concluded a week-long, statewide educational network television series directed to the youth in our high schools on wellness and lifestyles.

Within the last three months, business, industry, labor, insurance companies, physicians and hospitals have agreed to collaborate in a statewide utilization review and quality assurance program for the care of private-pay patients, to assure that their hospital dollars are well spent. We hope to have this program operating by early 1979. We will be the first in the entire nation to adopt such a cost-saving, quality-assuring program on so wide a scale.

You will search out many other fine ideas today on how to get the best in medical and health

care for the least dollars. I would like to stress a single word that should get far more attention from all of us as the coals of inflation heat up and intensify the threat of outright control of patients and their care by governmental bureaucracy. That word is productivity.

A great many business executives, labor leaders, and economic experts recognize that the best answer to steadily rising costs is improved productive efficiency, greater output per hour of effort. Unfortunately, the general productivity trend in America is downward. The reversal of this trend is crucial to society. More important to us today, can productivity improvement be applied in the service elements of our society, such as hospitals and doctor's offices, as well as on the factory production line? I believe it can.

The State Medical Society of Wisconsin, through its Physicians Alliance, is beginning to learn about the socioeconomic factors at work in medical and health care settings. For example, we are implementing a uniform claim form for doctors' offices for use in making claims services from all third-party payers. This may sound like a simple thing. It was difficult to get agreement among physicians and carriers, but once in use statewide and combined with CPT-4 procedural terminology, it may save up to a million dollars a year in doctors' office overhead, to say nothing of the relief it can provide to insurance companies.

We are recognizing how government rules and regulations can simultaneously suppress productivity and increase costs in hospitals and medical practice.

To illustrate, each hospital is estimated to have about 1,200 separate rules imposed upon it from one governmental agency or another. Compliance with these rules costs about $5 per patient-day on each hospital bill, or a total in excess of $29 million per year for the people of Wisconsin.

Some rules are necessary for quality assessment, but other rules have imposed thousands of dollars in proficiency testing fees for laboratories with little or no useful testing being performed.

It is critical that we come to understand the link between maximum output and the strength of the free enterprise system.

One of the more essential needs in health care productivity is working out ways of measuring that productivity, taking into account all of the resources that go into it, labor, materials, and capital outlay.

We have only entered upon the edges of such measurement with Certificate of Need and its application by the HSAs. Our Certificate of Need standards are a kind of infantile numbers game. Too often, they have been developed by those who know little or nothing about either health or disease, who have operated under forced draft to meet some senseless bureaucratic deadline.

Admittedly, it is difficult to apply productivity concepts to health service activities because of the problem of defining output. What is or should be the output of a doctor? A hospital? A dentist? A physician's assistant? How does one measure outcome? But, such measurements must be developed or the productivity gap will widen and the cost spiral will accelerate.

The problem for physicians and hospitals will become more acute as regulation increases. Regulatory bodies will not allow doctors and hospitals to continue to raise prices at present levels of inflation. Thus, the only way these professionals and institutions can continue to remain fiscally solvent is to make gains in productivity.

Coercion in the form of selectively applied wage-price controls or "caps" imposed by the insurance industry or government are not effective in controlling total cost. There are too many ways to "beat the system;" they become counterproductive by generating active resistance and stimulating new methods of circumvention.

We in medicine need the help of industry and business to analyze the productivity and efficiency of the myriad of new developments in health technology. The planners say, for example, that CT scanners are nothing more than money machines. On the contrary, medical economists say that CT scanners save up to 10 times their cost per procedure in elimination of hospital days and other diagnostic tests—at greater safety and comfort to the patient. There must be a better way to evaluate such problems before we design an entire health care system based upon some ill-conceived notions glibly expressed with sufficient frequency that they become ensconsed as fact in the literature of health planning.

We in medicine need the help of the insurance industry and the interest of employers and unions to gather the facts of length of stay, use of diagnostic tests, methods of treatment *vs* outcome . . . . not just for a few subscribers but for all subscribers statewide, for all patients in all hospitals . . . . so that the full and true picture of necessity and appropriateness of care can be measured, and, where necessary, improved. The new Wisconsin Review Foundation intends to address the total problem of efficiency and productivity in medicine and hospitals and needs everyone's support.

In summary, we need each other in our search for cost containment. As Carol Burnett says, "I'm so glad we got together;" but more importantly, let's stay together! The password for all of us should continue to be Quality in Care but we must add an additional aspect—Cost Aware. *Remember, tomorrow is waiting for us!* ■

Special to the Journal

Medical-educational interaction for exceptional children

Paul A Sommers, PhD; George G Griese, MD and Frederick W. Theye, PhD, Marshfield, Wisconsin and Wayne A Jones, PhD, Syracuse, New York

• Medicine and education have joint responsibilities for children who have exceptional health and educational needs. A medical-educational model is presented which illustrates how the disciplines of medicine and education can effectively interact for exceptional children.

INTERACTION OF medical and educational services for exceptional children often occurs on a randomized basis rather than as a planned and organized effort. What may appear to be a rather simple solution to a complex problem necessitates further clarification. Most states have laws making services for children with exceptional needs mandatory. At the Federal level, Public Law 94-142 "Education for All Handicapped Children Act"[1] mandates that all necessary services be provided to every handicapped child; but a clear interpretation of "who is to do what and in what order" has remained a puzzle.

Least restrictive alternatives

Educational implications

Educational programming for exceptional children currently is being assessed for its philosophical and practical applicability. As noted by Phillip Jones, Past President of the Council for Exceptional Children, in 1976,[2] the "mainstreaming" concept, which has been a key factor in recent years in the programming for exceptional children, is out.

Public Law 94-142 has language which calls for serving handicapped children in the 'least restrictive environment.'

The least restrictive alternative in Wisconsin[3] is designed to assist special education planners and school system personnel to provide a broad range of service alternatives for children and youth with exceptional educational needs.* The delivery of special educational services is fundamentally based upon the principle of the least restrictive alternative enunciated by the courts in a recent series of litigations. Basically, courts have insisted that when a governing organization seeks to restrict a person's fundamental liberty, it shall use the appropriate least restrictive alternative. For schools, this option implies that among all possibilities for placement within the general educational system, children with an exceptional educational need shall be placed where they can obtain the best education with minimal restriction from their nonexceptional peers. Inherent in this concept is the implication that regular education has

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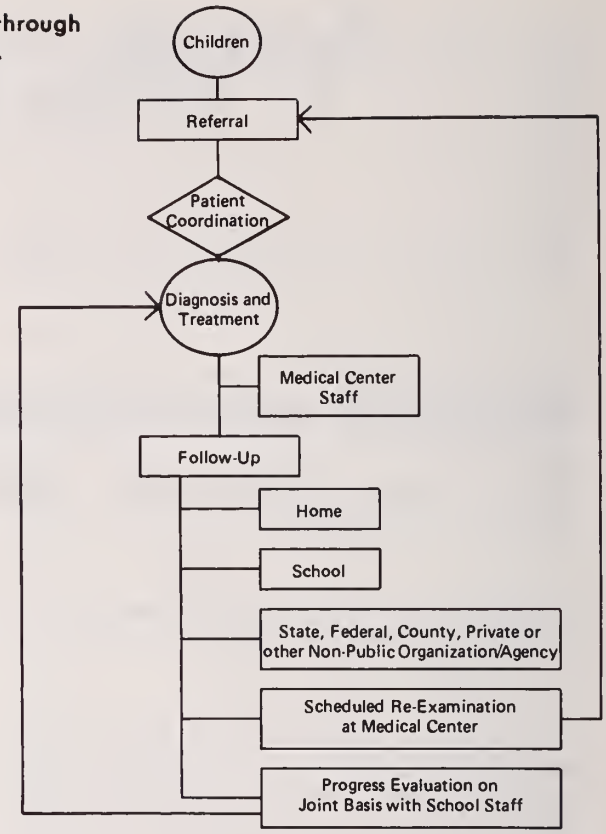
*Physical, crippling or orthopedic disability; developmental disability or mental retardation; emotional disturbance; hearing disability; visual disability; learning disability; or speech/language disability.

Figure 1—An overview of the patient flow through procedure beginning with referral of child.

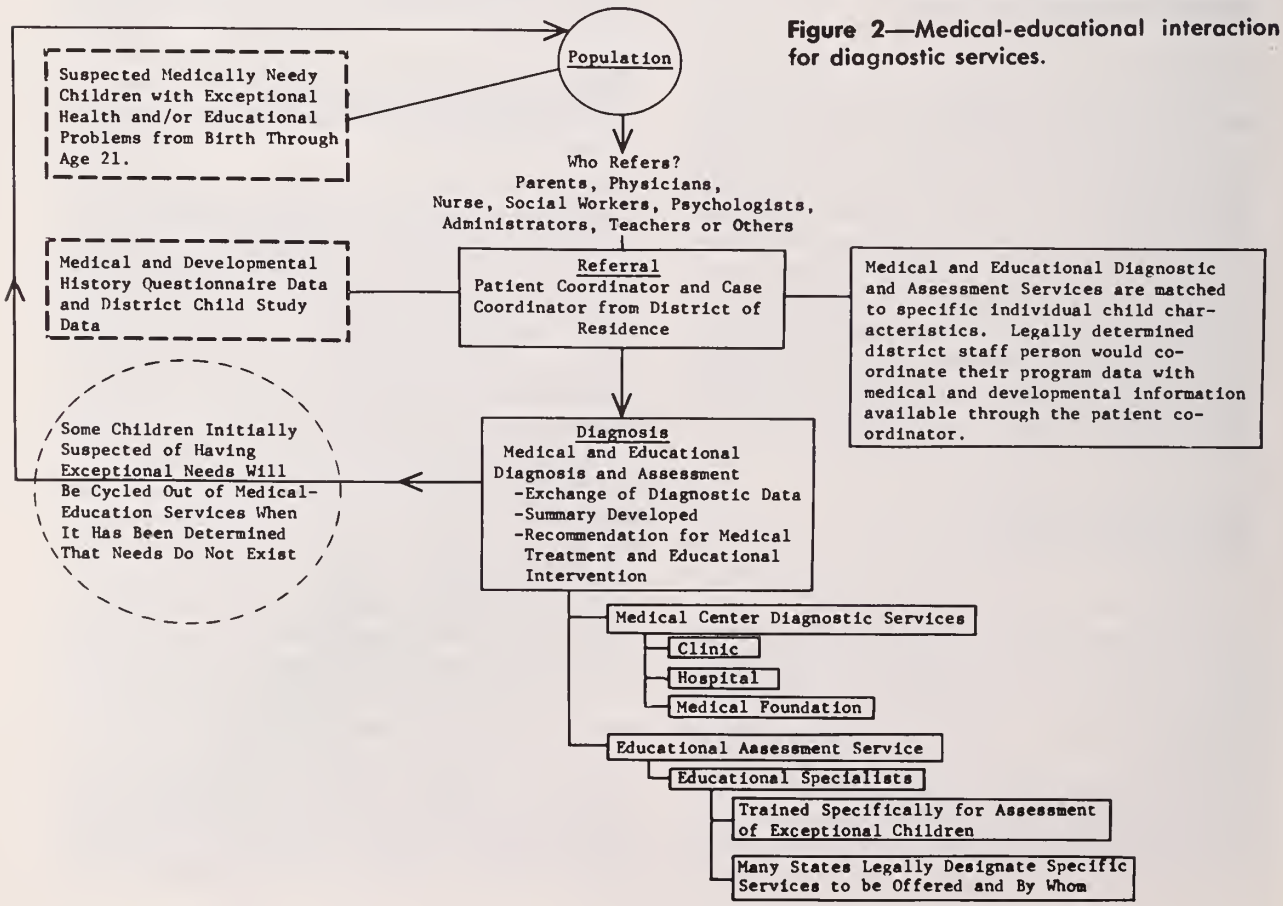


some appropriate program elements unavailable in special education, hence the need to consider accommodations within the mainstream where appropriate.

Medical implications

Although smaller than once believed, a number of children with exceptional needs require some form of supportive medical care. Subsequently, a comprehensive plan for the medical-educational needs of the exceptional child is essential. Clinics and medical centers that provide supportive health care services (*ie,* pediatric, neurology, psychological, psychiatric, physical/occupational therapy, and the like) to exceptional children must become aware of each child's learning needs. Health care services are also definable on "a least restrictive basis." For example, the more complex the medical problem, the more restrictive the health environment of the child may become. From a medical service delivery standpoint, as the child's condition improves or deteriorates, the restrictiveness tends to decrease or increase.

Figure 2—Medical-educational interaction for diagnostic services.



Medical-educational interaction

The initiation of comprehensive medical-educational services for exceptional children must begin and remain in the form of appropriate and continual communications. Educators must make their needs known to medical staffs serving children from their schools. Health care professionals must provide jargon-free diagnostic and treatment information in a format appropriate for inclusion into the child's learning program. Educators must clearly specify the questions for which they would like medical information in advance or at the time of the clinic visit. This procedure will enable the medical staff to present clinical data in light of educational implications while the child is being seen at the medical center. If a useful individual education program (IEP) is to be developed and implemented for the child with exceptional needs (as mandated in PL 94-142), the coordination of basic educational and supportive health services is essential.

Communication

Interdisciplinary planning and development are essential elements in the provision of comprehensive child care services. A consideration that is equally important is the involvement of parents. Parents may hold the key to effective planning and program implementation. For example, if parents are reluctant to actively involve each agency or organization that has worked with their child, the primary learning case coordinator of the child's program is at a decided disadvantage. Appropriate communication must be established with each parent on a personal level. A trust must be built and continued from the initial contact forward. Without trust and open communication, the likelihood of attaining program success will be remote. Parents are the most important people in the lives of children being served and their cooperation is essential to all efforts.

Followup

Followup procedures to verify consumer satisfaction with medical care is a vital consideration. A technique has been implemented by the Comprehensive Child Care Center which directs survey questionnaires towards each parent and case coordinator (*ie,* teacher, social worker or other individual responsible for child's learning/development program in their home community) after services have been provided.[4] Questions are asked each of these respondent groups about their satisfaction with specific and general medical services received by the child. The information received by these consumers is used to monitor program operations.[5] An example of the data collected is illustrated by one question which appears on both the parent and case coordinator survey:

> "Were you pleased with the overall service provided by the Comprehensive Child Care Center?"

Over the first 24 months of the program, longitudinal ratings of 84%; 84%; and 83% were given by parents and ratings of 75%; 71%; and 75% by case coordinators (evaluation periods: [1] July 1, 1975 to June 30, 1976 of 130 children; [2] July 1, 1976 to Jan 31, 1977 of 63 children; and [3] Feb 1, 1977 to July 31, 1977

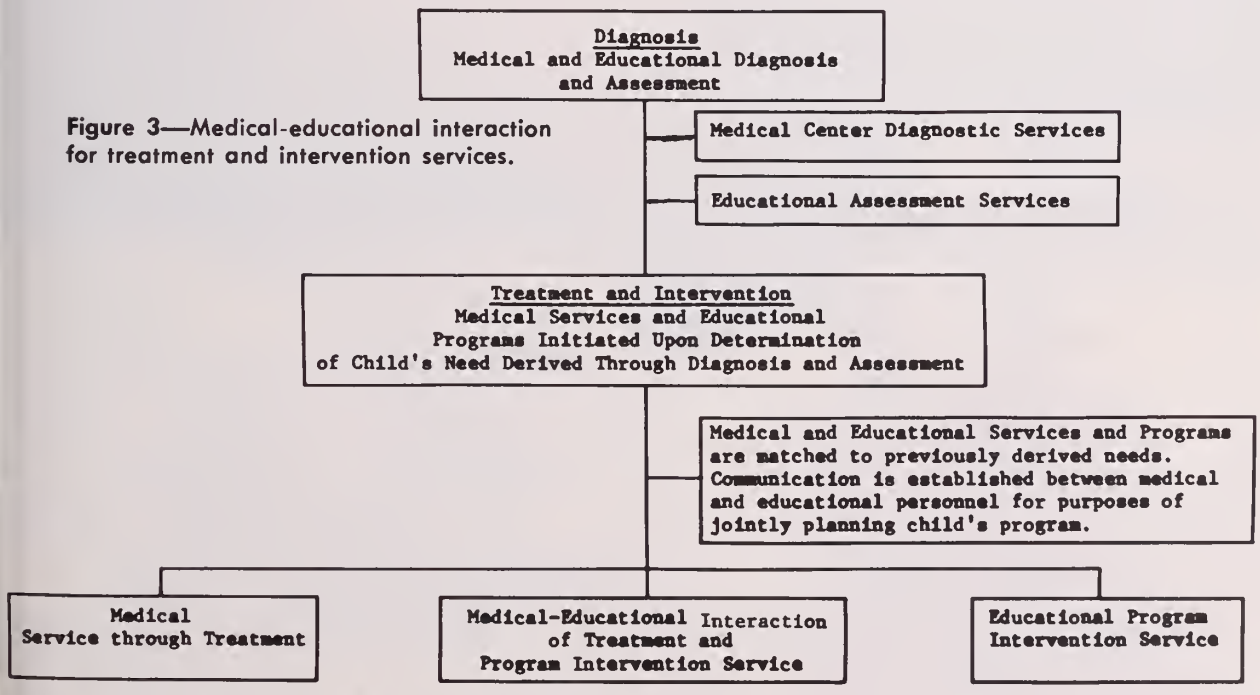


Figure 3—Medical-educational interaction for treatment and intervention services.

of 70 children). Along with data obtained from other areas this input has been used to modify and refine the services. This procedure is now used on six-month intervals.*

*Contact author for further information.

Organizational elements of an operational model

The Comprehensive Child Care Center of the Marshfield Clinic serves children (birth to 21 years of age) who have exceptional needs. A basic patient flow system functions to centralize all communication and is illustrated in Figure 1.

Figure 2 reflects the merger of medical-educational procedures for diagnostic purposes. Figure 3 indicates medical-educational interaction for treatment and intervention services.

The overall operation of a medical-educational interaction system is reflected in Figure 4 which shows the basic patient flow procedure with consideration given to referral, diagnostic, and treatment/intervention considerations.

Summary

Planned activity to integrate medical and educational services for children with exceptional needs will facilitate more efficient services. A medical-educational interaction model has been presented in this report which warrants further examination and perhaps consideration for implementation by other medical service providers.

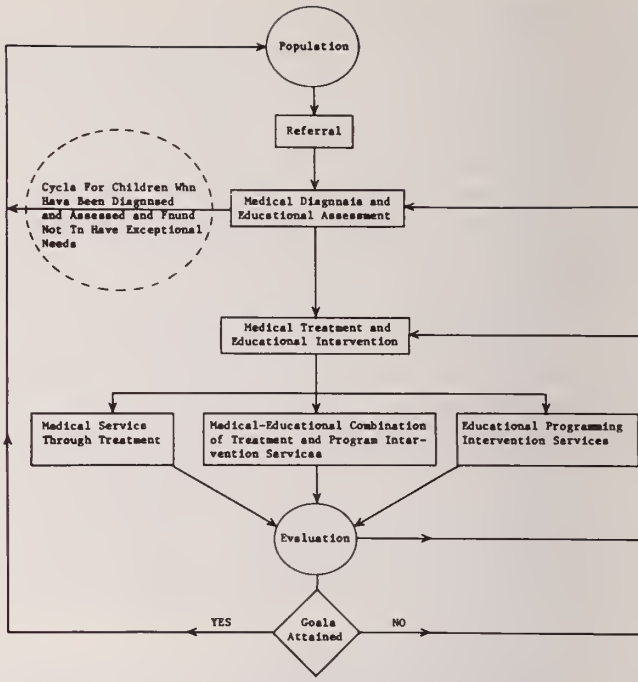


Figure 4—A medical-educational interaction system.

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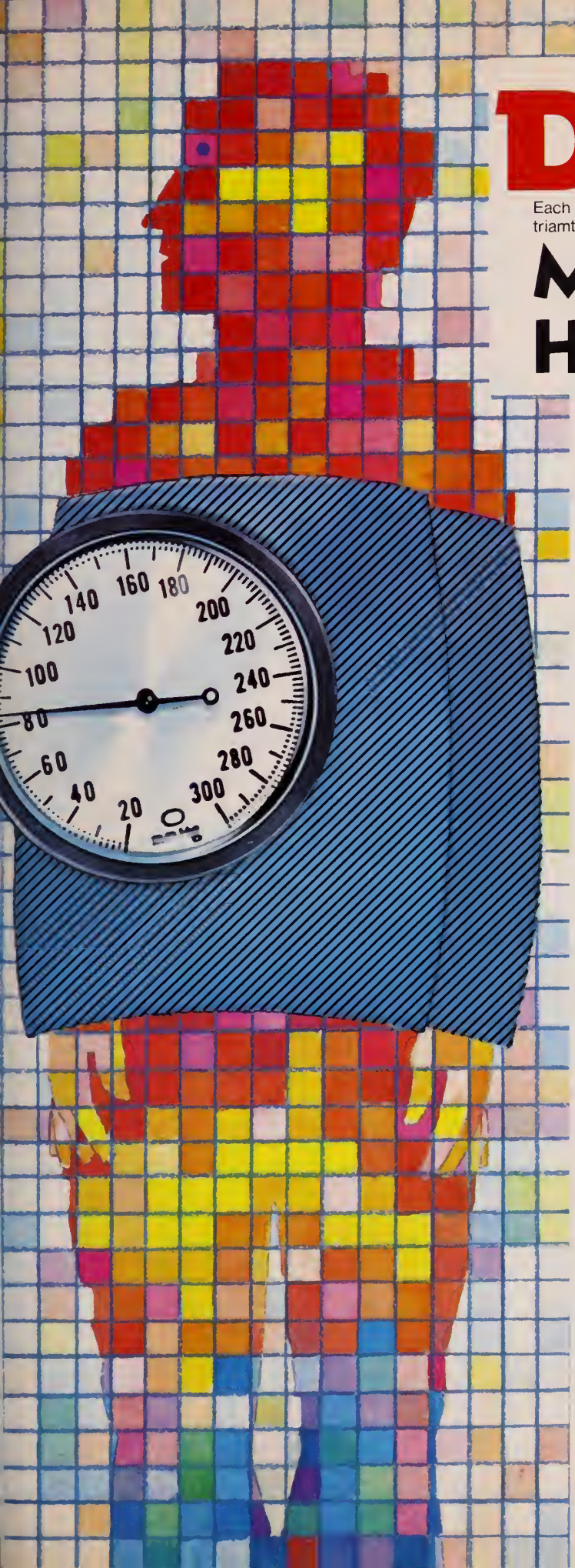
Complete literature available on request from Professional Services Dept. PML.



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Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with. autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste, headache; nervousness, drowsiness; weakness, dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
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Refer to: Fletcher FW: Acute myocardial infarction—a Northwoods experience. *Wisconsin Med J* 78:25-28, Feb 1979

Key words: Myocardial infarction, coronary artery disease, electrocardiographic monitoring

Acute myocardial infarction —a Northwoods experience

Fred W Fletcher, MD, Eagle River, Wisconsin

CORONARY ARTERY DISEASE, and myocardial infarction (MI) specifically, is the most important single cause of death in the United States. Many of these deaths occur in the prime of life, and for that reason reduction of this mortality has become a critical aspect of health care.

The capability of the coronary care unit to significantly reduce mortality in the treatment of the patient with acute myocardial infarction has been demonstrated repeatedly in the past decade.[1,2] This report is a review of the author's initial 30 months' (October 1975 through March 1978) experience with continuous cardiac rhythm monitoring in a small community hospital in northern Wisconsin.

Eagle River Memorial Hospital is a small community hospital (41 beds) located in the heart of northern Wisconsin's vacationland. Recent census figures show Wisconsin's northern counties' population growth was 5.8 percent from 1970 to 1975 while the remainder of the state was growing by 1.6 percent. Projected into the future, the population of northern Wisconsin could increase by nearly 50 percent over the next two decades. In addition, tourism is expanding in all seasons including the winter months where on a single weekend (World Championship Snowmobile Derby) an estimated 40,000 persons were in the Eagle River area. This combination of factors results in the potential for multiple medical emergencies including acute myocardial infarction.

Extensive expansion and renovation of the hospital has been accomplished within the last two years as the result of a federal grant through the Hill-Burton Act combined with a successful community fund drive. The Coronary Care Monitoring Unit has been an integral part of the modernization of the facility. The monitoring equipment includes hardwire bedside monitors (2) and ambulatory telemetry monitors (2).

The usual protocol for monitoring acute myocardial infarction is five to seven days of hardwire monitoring followed by an additional four to five days of telemetry monitoring. Telemetric monitoring has been extended in some instances when an unstable cardiac rhythm warrants. Cardiopulmonary resuscitation is performed in the usual manner with the Lifepak 5 being utilized to administer DC countershock.

Twenty-four patients with acute myocardial infarction were treated during the period. A diagnosis of acute myocardial infarction was made if at least two of the following three criteria were present: (1) a compatible clinical history, (2) typical enzyme changes, and (3) classical electrocardiographic (ECG) findings. The age, sex, and localization of infarction are presented in Table 1. Ventricular tachyarrhythmia was the most frequently encountered dysrhythmia in this

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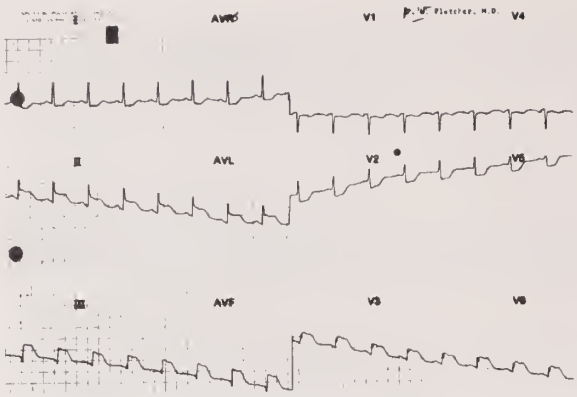

FIGURE 1—Acute inferior myocardial infarction.

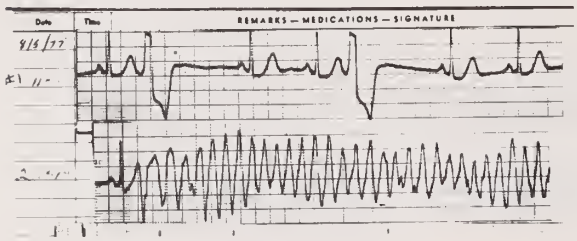

FIGURE 2—Sinus bradycardia with premature ventricualr contractions followed by acute ventricular tachycardia (R on T phenomenon).

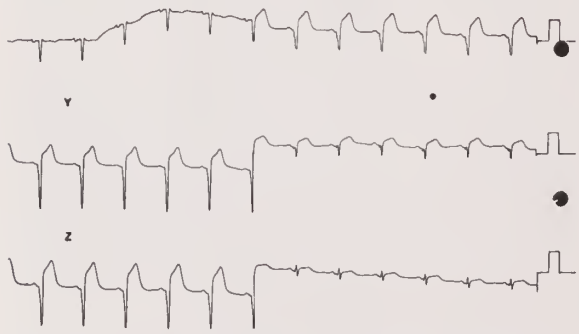

FIGURE 3—Acute anterior myocardial infarction. Persisting ST segment elevation suggestive of ventricular aneurysm formation.

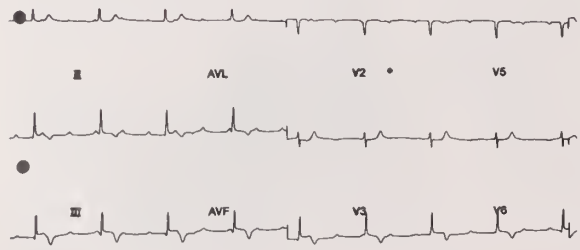

FIGURE 4—Complete AV dissociation associated with acute inferior myocardial infarction. Atrial rate 120-ventricular R 48.

Table 1—Age, sex, and localization of acute myocardial infarction in 24 cases

SEX	MALE (18)	FEMALE (6)
AGE	Range 33-76 Average = 60.7	Range 60-74 Average = 68.3
LOCALIZATION		
Inferior (Inferolateral)	10	4
Anterior	8	2

series and required DC countershock on at least one occasion in six of the cases, or 25 percent. Later complications included ventricular aneurysm formation and perforation of the interventricular septum, both terminating in a fatal result.

The following four cases are presented in detail as they exemplify the magnitude of the complications, and postmortem clinicopathologic correlation is available in two of the four cases.

CASE REPORTS

Case 1. A 76-year-old white male was admitted to the hospital in September 1977 complaining of left-sided anterior chest pain. Initial electrocardiographic studies revealed ischemic ST segment changes which regressed by the following morning. The evening following admission, the chest pain on the left side recurred and was associated with mild hypotension. Repeat electrocardiographic studies revealed changes of acute inferior myocardial infarction (Fig 1). Within the next hour the course was complicated by an episode of acute ventricular tachycardia which was successfully converted following intravenous administration of lidocaine and procainamide hydrochloride (Pronestyl®). Serum creatine phosphokinase rose to a peak of 1,700 units (normal range: 45 to 80 units). He was continued on maintenance Pronestyl®. Digitalis was added for paroxysmal supraventricular tachycardia. On the eleventh hospital day he suddenly developed recurrent ventricular tachycardia requiring DC countershock at 320 Watt-seconds to convert. His subsequent hospital course was uneventful, and he was discharged home. He has gradually resumed his preinfarction activity level and is free of congestive symptoms and anginal pain on maintenance dosages of digitalis and diuretics.

Case 2. A 50-year-old white male was admitted to the hospital in June 1977 complaining of severe left-sided chest and arm pain. Within 10 to 15 minutes after admission, he developed acute ventricular tachycardia-fibrillation which was successfully converted following three DC countershocks at 300 Watt-seconds. Electrocardiographic studies revealed changes of acute anterior myocardial infarction. Serum creatine phosphokinase rose to a peak of 2,031 units. The rhythm had stabilized by the following day, and transfer was effected to a downstate referral center utilizing the usual precautionary

measures. The subsequent hospital course was uneventful, and he was discharged home to complete convalescence. He has since had arteriography and bypass surgery at another center and has returned to work.

Case 3. A 68-year-old white male was admitted to the hospital in August 1977 complaining of severe retrosternal chest pain. He was placed on a monitor immediately and was noted to have sinus bradycardia with occasional premature ventricular contractions. This was followed by an episode of acute ventricular tachycardia which was successfully converted following DC countershock at 300 Watt-seconds (Fig 2). Electrocardiographic studies revealed changes of extensive acute anterior myocardial infarction. Serum creatine phosphokinase rose to a peak of 2,310 units. Serial electrocardiographic studies revealed persistent ST segment elevation over the anterior wall highly suggestive of ventricular aneurysm formation (Fig 3). He was transferred six days later via the Mobile Coronary Care Unit to University (of Wisconsin) Hospitals where he died after eight days of intractable pump or power failure. Postmortem examination revealed marked thinning of the anterior wall of the left ventricle as well as a 1.0 cm perforation of the interventricular septum.

Case 4. A 67-year-old white male was admitted to the hospital in April 1977 with acute inferior myocardial infarction complicated by congestive heart failure. He was readmitted six weeks later with acute pulmonary edema superimposed on chronic low-grade congestive heart failure. He was mildly hypotensive and oliguric. Therapy included continuous dopamine infusion at 12 to 24 mcgm per kg per minute plus high dosage of intravenous furosemide (Lasix®) (480 mg per 24 hr) to maintain satisfactory blood pressure and urine output. He was transferred to St Joseph's Hospital in Marshfield where coronary arteriography and left ventriculography revealed severe triple vessel disease plus a large aneurysm of the posterior wall of the left ventricle. Surgery was planned on an emergency basis; however, he died before surgery could be performed. Postmortem examination confirmed the arteriographic findings.

DISCUSSION

The effectiveness of coronary care units in small community hospitals has been evaluated in detail as a result of a recent cooperative study in Michigan conducted by the University of Michigan in Ann Arbor and funded by the Kellogg Foundation.[3] Coronary care units were established in 29 hospitals with fewer than 150 beds and mortality statistics compared with three large referral center hospitals between the years 1969 and 1974. Crude mortality rates from acute myocardial infarction in the small community hospitals were 14.5 percent, slightly higher but not significantly different from the larger hospitals (11.5%).

The study concluded that small community hospitals do allow effective coronary care providing a reasonable level of activity is achieved. An additional report from Appleton Memorial Hospital relative to Remote Electrocardiographic Monitoring in Acute Myocardial Infarction also revealed a significant decrease in mortality as compared to nonmonitored patients, but not to a level achieved in an effective coronary care unit environment.[4] Comparison with concurrent nonmonitored cases or with a comparable period prior to the initiation of a coronary care unit was not considered possible in the present study due to multiple uncontrolled variables.

Ventricular tachyarrhythmias constituted the most frequent dysrhythmia in the early stage of acute myocardial infarction in this series. Frequent multifocal premature ventricular contractions with short runs of ventricular tachycardia occurred in a high percentage of cases in the initial 24 to 72 hours of hospitalization. Lidocaine administered via bolus and continuous drip augmented by Pronestyl® successfully terminated the lesser unsustained episodes. Four patients with sustained ventricular tachycardia-fibrillation were unresponsive to medical management alone and were successfully resuscitated utilizing conventional techniques including DC countershock. Two patients in these cases (Cases 1 and 2) are alive and well today, while the other two died following transfer to referral centers.

The two additional cases of ventricular dysrhythmia occurred in the later convalescent stage and accounted for the two inhospital deaths in this series. Significant points regarding these two cases are that telemetry monitoring and the intravenous line had been discontinued in anticipation of discharge from the hospital. Both events occurred immediately after eating, were associated with vomiting and presumed tracheobronchial aspiration which undoubtedly influenced the final outcome.

The patient in Case 3 was resuscitated initially; however, he died at a referral center of severe pump failure associated with perforation of the interventricular septum. Rupture of the interventricular septum is an uncommon but lethal complication of acute myocardial infarction. Long and Cohen[5] reported a review of the literature in 1976; and, including their own three cases, they found a total of 75 septal ruptures associated with acute myocardial infarction. Successful surgical repair of the septal perforation has been reported in the later convalescent stage and more recently as an emergency procedure within three weeks after infarction.[6,7]

The associated finding at autopsy of marked thinning of the anterior wall is interesting in view of the electrocardiogram revealing persisting ST

segment elevation. It is highly likely that had the patient survived an aneurysm would have formed.

Case 3 is discussed in detail, and an additional patient with multiple bouts of ventricular tachycardia-fibrillation was transferred to University (of Wisconsin) Hospitals in Madison via the Mobile Coronary Care Unit where he died of pump failure. The cause of death in this instance also was felt to be a rupture of some variety; however, postmortem examination was not performed.

Case 4 demonstrates the complication of ventricular aneurysm which occurs in 15 to 20 percent of cases of acute myocardial infarction.[8] The aneurysm is usually anterior in location, corresponding to occlusion of the anterior descending branch of the left coronary artery. Posterior wall aneurysms, although rare, do occur, and in this instance the aneurysm was extremely large and undoubtedly accounted for the intractable pump failure with severe congestive heart failure. Again, ventricular aneurysm is amenable to surgical intervention as was being planned in this case.[9]

A single case of bradyarrhythmia occurred in the form of complete AV dissociation. In this instance the ventricular rate was relatively slow (Fig 4). Temporary transvenous pacing was instituted. Transfer was effected to St Joseph's Hospital, Marshfield, where the pacing catheter was subsequently removed and the patient recovered uneventfully. This patient also has returned to full activity and is angina-free. It should be emphasized that this individual had sustained an inferior infarction presumably due to occlusion of the right coronary artery. The SA and AV nodes are supplied by branches of the right coronary artery in 80 to 85 percent of humans; and therefore, the potential for this type of arrhythmia is much greater in inferior infarction, and temporary pacing may be necessary.

Transfer capability is a most important aspect of management of acute myocardial infarction in our setting. Marked instability of rhythm necessitating around-the-clock nursing care handcuffs our nursing staff at the height of seasonal influx. This combined with severe pump failure may indicate the need for more specialized diagnostic and therapeutic modalities available only at downstate regional referral centers. Patient and family pressure to return to their home area resulted in the transfer of three patients following initial stabilization. Multiple modes of transfer have been utilized during this two-year period. These include our local rescue vehicle with monitoring and life-support equipment, air-ambulance with similar equipment, and finally the cadillac of transport vehicles—the Mobile Coronary Care Unit from the University of Wisconsin Medical Center under the supervision of Dr Marvin Birnbaum—has been utilized in two instances for transfer. Eight patients were transferred during the two-year period without a single in-transit death.

SUMMARY

Twenty-four cases of acute myocardial infarction treated during the initial 30 months of coronary care monitoring in a small community hospital in northern Wisconsin have been presented. The immediate inhospital mortality of two of the 24 patients, or 8 percent, is a most gratifying statistic. This must be viewed with the fact that several patients were transferred relatively early in their course and were understandably more severe cases. Three deaths occurred at the referral center during the acute stage with two additional late deaths resulting in an overall mortality rate of 7 of 24, or 29 percent, over the 30-month period.

It should be stressed that many lives can be saved at the local level with proper equipment and knowledgable personnel that otherwise could not survive lengthy ambulance transport. Appropriate transfer is then necessary to regional referral centers for specialized diagnostic and therapeutic modalities, including surgery when indicated. Finally, in spite of all presently available expertise, a certain number of cases of acute myocardial infarction are doomed to death due to the catastrophic complications of this disease process.

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Refer to: Boedecker RA, Sty JR, Babbitt DP: Large intracranial arteriovenous malformation confined solely to the dura; case report. *Wisconsin Med J* 78:29-30, Feb 1979

Key words: Arteriovenous malformation, brain scanning, technetium pertechnetate

Case report

Large intracranial arteriovenous malformation confined solely to the dura

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Milwaukee, Wisconsin

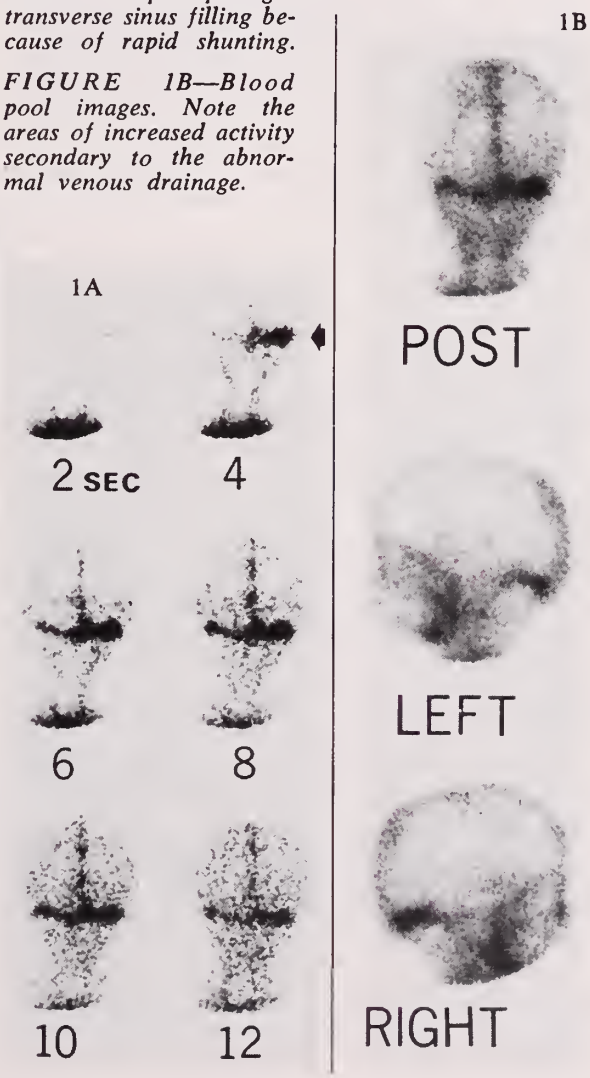
INTRACRANIAL ARTERIOVENOUS malformations (AVM) may receive part or all of their blood supply from meningeal branches of the external carotid arteries, internal carotid arteries, or vertebral arteries. Consequently, the malformation may be classified on the basis of arterial supply, for example pure pial, mixed pial and dural, or pure dural. AVMs that are entirely pial in location are supplied solely by cerebral or cerebellar arteries. Mixed pial and dural malformations receive their blood supply not only from cerebral or cerebellar arteries but also from meningeal vessels. Pure dural malformations are limited to the dura and receive only meningeal contribution.[1,2]

Discussion. Most AVMs are readily detected by both computed tomography and radionuclide imaging. This is especially true when the computed tomographic study is followed by intravenous infusion of contrast and the radionuclide angiogram is included as part of the brain scanning technique. In our population approximately 10% of the AVMs discovered by the radionuclide angiogram are clinically unsuspected.

Case report. In our case the radionuclide angiogram was performed using the posterior projection after an injection of technetium pertechnetate (8.3 mCi/m^2). The study demonstrated immediate filling of the transverse sinuses (Fig 1A). The blood pool brain images demonstrated focal areas of increased activity in several areas (Fig 1B).

FIGURE 1A—Radionuclide angiogram. Arrow marks prompt right transverse sinus filling because of rapid shunting.

FIGURE 1B—Blood pool images. Note the areas of increased activity secondary to the abnormal venous drainage.



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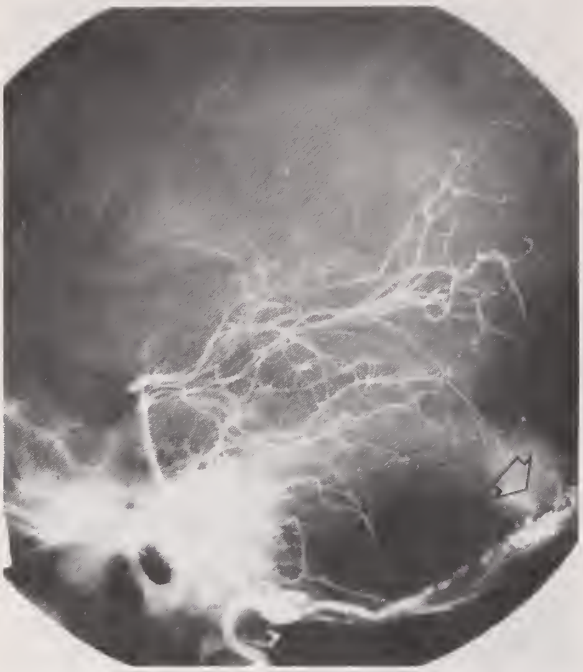

FIGURE 2—Lateral vertebral angiogram. The distribution of the posterior cerebral and cerebellar arteries is normal. A hypertrophied posterior meningeal branch of the vertebral artery supplies the transverse sinus. Note the rapid shunting (arrowhead).

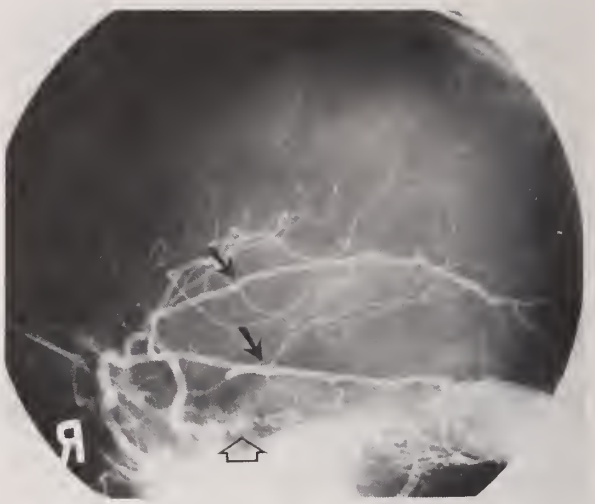

FIGURE 3—Right common carotid arteriogram. The posterior branches of the middle meningeal artery (solid arrowheads) and the meningohypophyseal branch of the internal carotid artery (open arrowhead) shunt rapidly into the transverse sinus. Note more rapid filling of the dural branches at the expense of intracerebral perfusion.

FIGURE 4—Venous phase of the right common carotid arteriogram. These large dilated draining veins account for part of the abnormality noted in the radionuclide blood pool images.

Cerebral angiography was performed to delineate the precise anatomic abnormality in order to decide if surgical correction or catheter embolization would be feasible (Figs 2,3,4).

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Abstracts

Gastric bezoars from swallowed string—A rare complication of esophageal dilatation

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JAMA 240:855-856 (Sept 1) 1978

A 65-YEAR-OLD WOMAN had swallowed strings 26 years previously for dilatations for achalasia of the esophagus. She complained of a bad taste in her mouth and inability to eat a full meal for four months. Upper gastrointestinal x-rays revealed two filling defects in the stomach which were found to be bezoars at gastroscopy. Endoscopic removal was not possible, so surgery was performed; and the two bezoars were removed. The largest measured 2.5 x 2 x 2 cm, and both were found to be rock-like masses of matted string.

This complication is so rare that cutting and swallowing a string used to guide esophageal dilators should not be abandoned. We recommend that the patient examine the stools to make sure the string passes. If it does not do so within a week or two, endoscopic removal should be easy if the string is in the stomach and has not become a rock-hard mass. ■

Refer to: Falk VS: Trichobezoar. *Wisconsin Med J* 78:31, Feb 1979

Key words: Trichobezoar, bezoar

Trichobezoar

Victor S Falk, MD, Edgerton, Wisconsin

ALTHOUGH TRICHOBEZOARS (hair balls in the stomach) are relatively uncommon, the first case was reported in 1779; and in 1937 DeBakey and Ochsner[1] collected 172 cases from the literature. In the next 30 years only another 30 cases were reported. Certainly there have been more cases that have not been recorded in the literature. This case is being reported because of the sheer size of the bezoar, the relatively benign symptomatology, and the additional finding of hair in the patient's appendix.

Clinical Data. The patient was a 15-year-old girl who was seen in February 1978 solely because she was required to have a physical examination for participation in high school athletics. The patient casually mentioned that she had been aware of a mass in her upper abdomen for approximately five months, but she offered no complaints referable to the gastrointestinal system. There had been no weight loss. There was a firm, slightly tender mass in the epigastrium extending down to the umbilicus.

Upper gastrointestinal x-ray studies showed a large filling defect within the stomach despite the patient's insistence of an adequate fast. The radiologist favored the diagnosis of bezoar. The patient then underwent esophagogastroduodenoscopy and the endoscopist reported "a truly huge trichobezoar filling most of the stomach all the way from the gastroesophageal junction to the pylorus." Hair fibers could easily be identified, but the bezoar was obviously too large and the process too hazardous to attempt to remove it through the esophagus. The patient was quite well nourished and not at all anemic. Her hemoglobin was reported at 15.5 gm per 100 ml and the hematocrit reading was 45%.

Although the patient denied the ingestion of hair, her siblings volunteered that the patient had had long hair and lost much of it and that she ate most of it. The patient steadfastly denied this. The siblings also reported that on two occasions she had been found sniffing gasoline. On further questioning the patient's mother reported that she had been feeding her only baby food in half jar quantities. It is of significance that the patient's mother has had psychiatric problems.

FIGURE 1 — Barium meal study showing trichobezoar filling much of the stomach.

FIGURE 2 — Trichobezoar measuring 24 cm in length.

Under general anesthesia the bezoar was removed intact through an anterior gastrotomy. This was a matted mass of firm hair measuring 24 cm in length. An incidental appendectomy also was done. The pathologist found the lumen of the appendix to contain multiple hairs and indicated that the finding of hair in the appendix was most unusual. The patient was discharged on the sixth postoperative day and returned to school in two weeks. She is eating well and has rather close cropped hair.

Discussion. More than 90% of the cases of trichobezoar occur in females and more than 80% of these are under 30 years of age. It is usually found in girls who are unstable; and trichophagia, or hair eating, is usually one of the symptoms. Commonly there is abdominal pain, anorexia, nausea, vomiting, and weight loss. Gastrointestinal bleeding often causes anemia in advanced cases. Diagnosis is usually made by barium meal x-ray studies and confirmation is easily established by fiberoptic endoscopy. Treatment is operative and the operative mortality is almost zero where there have been no complications resulting from delay.

Recurrence of a trichobezoar has never been reported despite the history of emotional instability in many of the patients. Apparently the operation is traumatic enough to discourage the further ingestion of hair.

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Refer to: Sty JR, Boedecker RA: The advantage of ^{99}m technetium glucoheptonate imaging in acute bacterial endocarditis. *Wisconsin Med J* 78:32-33, Feb 1979

Key words: ^{99m}Tc-glucoheptonate, renal infarct, CVA, acute bacterial endocarditis, "flip-flop" phenomenon

Case report

The advantage of ^{99m}technetium glucoheptonate imaging in acute bacterial endocarditis;

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• A patient with acute endocarditis was imaged with ^{99m}technetium glucoheptonate, Tc (GH). The examination substantiated cerebral emboli and demonstrated clinically unsuspected renal infarcts.

INFECTIVE ENDOCARDITIS may be a complication of congenital[1,2] or rheumatic heart disease. Embolization occurs in 30 to 60 percent of patients with infective endocarditis. The more frequent organs embolized are the spleen, kidneys, and brain.

Case report. A 12-year-old boy with congenital aortic stenosis was admitted to our hospital after a sudden onset of left hemiparesis. On admission, his laboratory analysis included an abnormal cerebral spinal fluid with 200 white blood cells per ml, and positive blood cultures for *Staphylococcus* (coagulase positive). A radionuclide angiogram was performed in the anterior projection after an injection of 8.3 mCi/m^2 of ^{99m}Tc (GH). The angiogram demonstrated early decreased perfusion in the distribution of the right middle cerebral artery and late increased perfusion, "flip-flop" phenomenon of a recent cardiovascular accident (CVA) (Fig 1). The 60-minute delayed brain images demonstrated abnormal increased activity in the distribution of the right middle cerebral artery, and a second area of increased activity in the temporal-parietal area. A posterior view of the kidneys was obtained which documented wedge-shaped areas of

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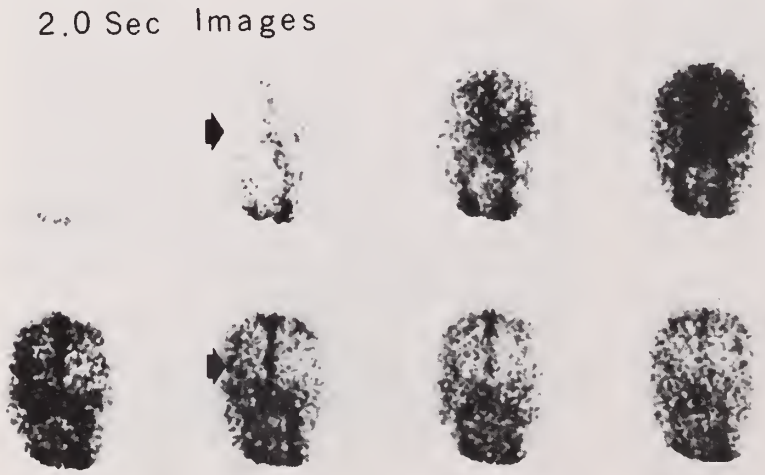

FIGURE 1—Radionuclide angiogram demonstrates the "flip-flop" phenomenon in the right middle cerebral artery distribution.

FIGURE 2—^{99m}Tc(GH) renal images. Note the photon-deficient areas secondary to infarctions.

infarction in both kidneys (Fig 2) which were unsuspected clinically.

Discussion. ^{99m}Tc (GH) appears to be a superior agent for brain imaging when compared with ^{99m}Tc diethylenetriaminepentaacetic acid (DTPA), and ^{99m}Tc pertechnetate.[3] In addition, ^{99m}Tc (GH) has a relatively prolonged localization in renal cortex.[4] A preclinical study[5] demonstrated that 15 to 25 percent of the injected dose in rats is taken up by the kidneys within one hour after injection. Because of the combined advantages of ^{99m}Tc (GH) over ^{99m}Tc DTPA and $^{99m}TcO_4$ in brain and renal images, ^{99m}Tc (GH) imaging is a reasonable approach in the initial evaluation of embolic phenomenon associated with infective endocarditis.

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Abstracts

Prognostic clues in managing left ventricular aneurysms

Donald C Mullen, MD; Leonard Posey, MD; Roger Gabriel, PA; Harjeet M Singh, MD; Robert J Flemma, MD; and Derward Lepley, Jr, MD, Medical College of Wisconsin, Milwaukee, Wis: *Ann Thorac Surg* 23:455-460, 1977

The likelihood of patient's doing well after left ventricular aneurysm resection is closely related to a high preoperative cardiac output and the presence of septal motion. The lower the preoperative cardiac index, the less likely it is that the patient will do well. Similarly, a lack of septal motion indicates a degree of left ventricular dysfunction so diffuse and so severe as to be virtually inoperable. If septal motion is present, resection of a left ventricular aneurysm is no riskier than myocardial revascularization without left ventricular disease.

Evaluation of septal motion can be made only by left anterior oblique ventriculogram, and both right and left anterior oblique views are necessary for adequate evaluation of the four major walls. When no motion is evident, operation is inadvisable.

Among 56 patients undergoing resection of left ventricular aneurysms and observed for 5 to 40 months postoperatively, 27 improved, 16 remained the same, 6 were worse postoperatively, and 7 died. Of the 49 patients who survived, all had detectable septal motion. Both patients who died early and two of the five who died late had no evidence of septal motion on preoperative ventriculograms. Outcomes were best for patients with preoperative cardiac indexes of 2.8 L per minute per square meter. ■

Risk factors and angiographically determined coronary occlusion

Alfred J Anderson; Joseph Barboriak, ScD; Alfred Rimm, MD, Medical College of Wisconsin, Milwaukee, Wis: *Am J Epidemiol* 107:8-14 (Jan) 1978

An association of coronary artery occlusion with age, prevalence of risk factors, and alcohol intake was determined by coronary arteriography in 1,635 male and 371 female heart patients. The degree of coronary artery occlusion was positively related to elevated cholesterol, elevated triglycerides, diabetes, age, and history of smoking for both male and female patients. Hypertension was related to the degree of occlusion only for female patients. Male and female patients who had a higher alcohol intake tended to have less extensive occlusion. No positive association was found between obesity and the degree of occlusion. When the patients were divided on the basis of age (<50 and ≥ 50 years) the findings did not differ. The lack of finding a relation between obesity and occlusion or between hypertension and occlusion for male patients differs from the general findings of epidemiologic studies on the relation between these risk factors and coronary heart disease. This discrepancy may either be explained by the way the patients were selected (*ie*, patients who underwent a diagnostic angiographic examination) or that obesity and hypertension are not directly related to coronary occlusion but influence occlusive disease through some secondary mechanism. ■

Book Review

Atlas of technetium bone scans

DENNIS L CITRIN, MB, ChB, PhD and J H McKILLOP. WB Saunders Company, Philadelphia-London-Toronto, 1978, pp 240 and 412 illustrations with a comprehensive literature review

Radioisotope bone scanning which images the skeleton using gamma emitting radioisotopes or labelled pharmaceuticals has become one of the most important and frequently requested diagnostic procedures in nuclear medicine. Development of ^{99m} technetium labelled phosphates and diphosphonates in 1972 permitted the production of consistently high quality bone scans suitable for routine clinical study of benign and malignant skeletal disease.

Bone scans indicate the dynamic response of bone to a disease process, while radiographs indicate the net result of bone destruction and repair. Any destruction of bone causes increased bone blood flow and metabolic activity due to new bone formation. These reactive processes cause a local increase in the concentration of the isotope or labelled radionuclide which is recorded by a rectilinear scanner or gamma camera as a 'hot spot.' Occasionally, disease affecting non-bony tissues may also produce a positive scan. Bone scans are often positive before any radiographic abnormality is visible, thus providing information that cannot be obtained by any other non-invasive procedure.

It is easier to identify an abnormality on bone scan than on a radiograph. but harder to determine the cause of the abnormality. The recommended technique for bone scanning is discussed in detail from the initial consultation request to the final scan review. Clinical situations where a bone scan is useful are described. The importance of combining bone scans with a complete physical examination, laboratory tests, and questioning about trauma and previous health problems is stressed. Examples of actual scans are used to illustrate details which can cause inferior scans and false interpretations, such as scheduling, injection technique, artifacts, obesity, and patient movement. Scans of many types of bone disease are shown with comments about procedure and interpretation. Comparisons of the results with different radionuclides and equipment are also presented.

A normal bone scan shows "bilateral symmetrical distribution of radioactivity about the midline with uniform or smooth gradation of activity along the spine." Areas where potential for error exists in normal scans (such as activity in the epiphyseal regions in children) are discussed. Radioactivity may also localize in certain non-bony tissues (urinary tract, normal breast, and cartilage) and accumulate due to certain soft tissue diseases (tumors, cerebral infarction, myocardial disease, and soft tissue calcification). Examples of these are shown.

Bone scans can be used to study benign and malignant bone tumors and metastatic bone disease. They can be used to stage malignancies prior to treatment, follow-up after primary treatment, to study radiologically difficult areas, to detect and localize metastatic disease, and to monitor treatment. Bone scans can also be used to study Paget's disease, arthritis, degenerative disease of the spine, inflammatory bone disease, and metabolic bone disease (hyperparathyroidism, osteomalacia, osteoporosis). In case of trauma it can be used to diagnose radiographically occult fractures, assess the age of traumatic lesions seen on radiographs, determine rate of fracture healing, diagnose non-union of fractures and bone grafts, and identify fractures of the femur neck. Radiotherapy, hypertrophic pulmonary osteoarthropathy, inflammatory disease in tissues near bone, hyperostosis frontalis interna, and fibrous dysplasia of bone can also be detected by scanning.

Bone scans can be relied on to provide highly significant clinical information, but the physician must be aware of the limitations as well as the relevance of bone scans to other radiological and laboratory examinations. Any health professional who will need to use or understand the techniques of nuclear medicine should find this summary of the present state of bone scanning extremely valuable. The photography of both normal and abnormal bone scans is striking and clearly illustrates the technical and clinical factors which can influence the information derived from the examination.

DOROTHY J BUCHANAN-DAVIDSON, PhD
Science Writer, WCCC ■

Abstracts

EEG recognition of Aicardi's syndrome

RUGGERO G FARIELLO, MD; RAYMOND CHUN, MD; JOSEPH M DORO, DO; J RAYMOND BUNCIC, MD; JOHN S PRITCHARD, MD, University of Wisconsin, Madison, Wis: *Arch Neurol* 34:563-566 (Sept) 1977

In 32 EEGs from six patients with Aicardi's syndrome a characteristic EEG pattern was found. This consisted of multifocal epileptiform abnormalities occurring on a burst-suppression pattern showing complete asynchrony between the two hemispheres. This pattern has been described so far only in Aicardi's syndrome. These characteristic EEG features are more readily found early in the course of the disease and occur less frequently six months after the onset of symptoms, at which time they are often replaced by multiple epileptic foci on a severely disorganized background. The EEG sleep pattern was profoundly altered in all stages. ■

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

The Wisconsin Clinical Cancer Center

The walls of the center are the farthest corners of the World

When the new Wisconsin Clinical Cancer Center Tower of the Clinical Science Center was dedicated Feb 21, 1978 in Madison, a pledge was made that its facilities and services would be used not only for the benefit of the citizens of Wisconsin or the United States but also for the benefit of people around the World.

The Center's three main divisions—Radiation Oncology, Clinical Oncology, and Research and Development in Cancer Control—have as their primary goal the providing of Wisconsin citizens with the most advanced diagnostic and treatment methods for cancer. The new Center has 52 beds exclusively devoted to the care of cancer patients; well-equipped surgical, radiotherapy, laboratory, and rehabilitation services; and new outpatient facilities. Coupled with patient care will be the training and education of health professionals in the many disciplines needed to provide complete medical care for cancer patients.

In order to help Wisconsin citizens in their home towns, networks have been developed to bring knowledge about cancer to the local communities. For example, a Colposcopy Network makes it possible for women who have an abnormal Pap smear to be carefully evaluated and often treated without extensive surgery. The Visiting Oncologist Program presents lectures and programs about cancer to over 4000 state physicians each year. A Wisconsin Oncology Group has been organized in which about 90 physicians meet quarterly to study cancer problems. The Wisconsin Council for Cancer Control with representatives of organizations having an interest in cancer also meets quarterly to discuss problems of mutual concern. The Cancer Information Service—the first of the toll-free telephone counseling services to be established—answers over 4000 calls

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

from both professional and lay people each year. This column, a quarterly newsletter *Cancern,* news releases, magazine articles, traveling exhibits, promotional materials, and descriptive pamphlets help tell people about cancer.

The Center's staff is in constant contact with the National Cancer Institute, the other nineteen comprehensive cancer centers, and most of the major medical and scientific research centers in the United States and around the World. Recently two members of our staff have been involved in teaching and demonstrating advanced diagnostic and treatment methods relating to cancer to medical professionals in several countries of South America. A medical exchange program has been established between the University of Wisconsin and Semmelweis University Medical School in Budapest. And the Center is actively working with the WHO and other international groups interested in the problems of cancer.

The clinical treatment of cancer patients is constantly being improved by participation in cooperative groups, such as the Eastern Cooperative Oncology Group which has connections with physicians in South Africa, Switzerland, France, and Italy. Other cooperative studies are being carried out with England, Switzerland, Japan, Russia, Australia, and Venezuela. Visitors from many countries such as Finland, Holland, Turkey, and Iran make it possible for the staff to be familiar with all the new diagnostic techniques and improvements being developed to treat various types of cancer.

Essential to improvements in clinical treatment is a strong program in basic research. Studies are in progress which will hopefully help improve chemotherapy and hyperthermia, determine the prognosis of a cancer more accurately, and predict an individual's susceptibility to cancer. Contacts with basic research scientists in Australia, Turkey, Japan, Venezuela, England, Germany, Hungary, and many other countries help speed the spread of this basic knowledge and its applications to clinical uses.

Cancer is a worldwide problem. With the dedication of this new Wisconsin Clinical Cancer Center, the staff is pledging its continued efforts to the strengthening of its goals to improve the understanding, diagnosis, and treatment of cancer for everyone.

—Dorothy J Buchanan-Davidson, PhD
Science Writer, WCCC

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976
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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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For prescribing information see opposite page

The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions.
However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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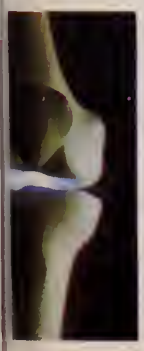

Motrin 400 mg TABLETS
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one more reason to prescribe Motrin.

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Motrin 400 mg TABLETS
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Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

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Unit of Use bottles of 120	NDC 0009-0750-26

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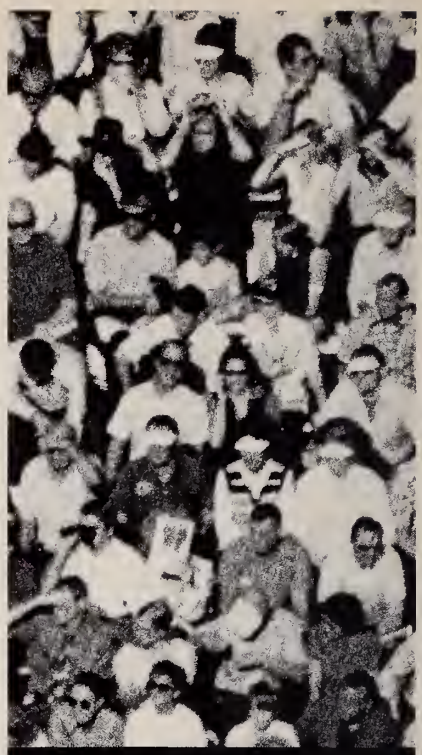

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Organizational SMS

SMS commission backs medical school freeze

The SMS Health Planning Commission has supported a special report by the State Health Policy Council that recommends the present freshman medical school class size at the UW Medical School and the Medical College of Wisconsin be maintained in 1980. The Commission supported the freeze on the condition that neither school is forced to refund new construction grants it has received from the US Dept of Health, Education, and Welfare in return for expanding enrollment.

Bernard Nelson, MD, acting vice-chancellor for health sciences at the UW, was present at a January 18 meeting of the Commission to speak for the medical schools. He argued that an increase in doctors was necessary to help alleviate shortages in rural areas.

John Peters, MD, Fond du Lac, a member of the Health Policy Council and the SMS Health Planning Commission, urged the Commission to support the HPC's recommendation to freeze current class size saying that failing to do so would result in an over-supply of physicians and increased medical costs. The decision to limit class size to present levels now rests with Governor Dreyfus and the Wisconsin Legislature.

In other action January 18, the Commission recommended that discussions get underway with Governor Dreyfus and Division of Health officials to assess public health needs in Wisconsin, who should provide public health services, and how these services should be financed. The request for a joint meeting between the Governor's office, Division of Health, and SMS is prompted by a recent decision of Robert Durkin, administrator of the Division of Health, concerning the redeployment of 108 public health positions. ■

GAC supports determination of death statute

The SMS Commission on Governmental Affairs January 10 voted to support a proposal by the Legislative Council's Special Committee Creating a Determination of Death Statute. The proposal, which may be introduced in the Legislature this session, does not actually define death but states what constitutes death *(ie,* irreversible cessation of all functioning of the brain) for medical and legal purposes.

The Commission also decided to reintroduce this session a bill which calls for mandatory testing for rubella of females entering the sixth grade and for women under 50 years of age who are not immunized against rubella and need to be.

On another matter, the Commission approved "in principle" legislation allowing the State to use JCAH (Joint Commission for the Accreditation of Hospitals) accreditation in lieu of the State's accreditation program for hospitals. It is anticipating that this would eliminate the duplicative system of accreditation on the part of the State and at the same time utilize the far more comprehensive and nationally recognized JCAH accreditation program.

In a communique to the Commission, the Wisconsin Hospital Association sought the State Medical Society's support for this issue in the State Legislature. ■

SMS annuity unit value: $2.13

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians, was $2.46 as of December 29, 1978. The unit value at January 31, 1979 was $2.13. ■

Local Alliance meetings underway

Local Physicians Alliance committees have already begun to meet regularly with state legislators for the new legislative session. The local "mini" Alliances are beginning their second full legislative session of meetings between both State Senate and Assembly members and local physicians. These meetings are being organized by Physicians Alliance field staff in close coordination with the State Medical Society lobbyists at the State Capitol.

Last session these regular meetings with state legislators proved to be the most successful organized political effort by the medical society. Local input between physicians and legislators is one of the primary goals of the Physicians Alliance program. The effort keeps legislators informed on the increasing numbers of medical issues and at the same time gives physicians another dimension of information fromWisconsin government. ■

Journal well read

The *Wisconsin Medical Journal* was one of 19 surveyed recently by an independent research firm. Some of the conclusions: well over 80% of the recipients of the WMJ read some or all of each issue; 12% read all or most of the scientific articles, 86% read them selectively; 20% read all or most of the SMS Organizational content, 51% read it selectively. Further details appear in an editorial in this issue. ■

Response to unified membership poll reported

Results have been tablulated of the unified membership poll the Society conducted during December of all member and nonmember physicians in Wisconsin. More than 57% of the approximately 4,500 member physicians in Wisconsin and 29% of the 2,696 nonmember physicians responded to the survey.

Currently in Wisconsin, a physician who wants to be a medical society member must join the county, state, and national societies. Without a unified membership rule, physicians could join all three societies as one option, or the county-state societies as another option.

Of the member physicians responding, almost 56% said they opposed unified membership, while about 45% were in favor of continuing the unified approach to membership in Wisconsin. Many of the counties responding had results indicating a close "race" between those who support unified membership and those who oppose it. Thirty-three of the 53 county medical societies had a majority of respondents opposing unified membership.

Of those physician members who *supported* unified membership, 71% indicated they would join all three organizations (CMS, SMS, AMA) if the unified membership rule were abolished in Wisconsin, while 5% said they would join only their county and state societies; 2% said they would not join any organization; and about 22% did not indicate a choice.

Of the 56% of member physicians *opposing* unified membership, more than 50% stated they would join all three medical organizations if unified membership were abolished, with about 34% indicating they would join only their county and state societies and about 6% giving no response.

Approximately 29% of the 2,696 nonmember physicians (including about 900 residents in training) in the state responded to the survey with a total of 92% opposing unified membership. Of this 92%, about 68% of the nonmember physicians indicated they would join county and state medical societies, 11% said they would join all three organizations if the unified membership requirement were abolished, and 14% said they would join no organization.

Sixty-four of the nonmember respondents *supported* unified membership, or about 8%. Of these, more than 73% indicated they would join the county, state, and national organizations even if unified membership were abolished in Wisconsin, with slightly over 6% saying they would join only the county and state societies and 0% saying they would not join any organization.

The SMS Council was to review results of the poll at its February 3 meeting in Madison. ■

LATE NEWS. At its February 3 meeting the SMS Council voted to place the issue of unified membership in Wisconsin squarely before the 1979 House of Delegates. At the H/D Annual Meeting in May the Council will introduce an amendment to the SMS Constitution to remove the unified membership rule. A constitutional amendment cannot be acted upon by the House until one year after its introduction. Therefore, a proposed amendment presented in 1979 would be acted upon at the 1980 Annual Meeting and become effective January 1, 1981.

Public Information Commission meets with Robert Durkin

Ways to improve communcations between the Division of Health and the State Medical Society was the topic of discussion at a recent meeting of the SMS Public Information Commission in Madison. At that meeting Robert Durkin, administrator of the Division of Health, said that he felt communications between the two bodies had been very good thus far and he expects this to continue. "While the Division and SMS have been through a rather difficult period recently on the Medicaid contract," Durkin said, the Division "badly needs the help of the Society and its commissions on many current issues facing it such as the EPSDT Program and prison health care."

In other action the Commission:

- Reaffirmed its support of an SMS statement on patient rights and responsibilities which the SMS Physicians Alliance has submitted to several legislators as an alternative to last year's Senate Bill 418 — defining patient rights and responsibilities.
- Approved SMS cosponsorship, with the Governor's Commission on the Status of Women, of a Women's Health Issues Conference slated for April 23 in Madison. The goals of the conference are threefold: 1) to educate participants about women's health issues, 2) to provide a forum for women to voice their health concerns, and 3) to formulate recommendations regarding women's health care to take to Wisconsin physicians at their Annual Meeting in May.
- Decided not to cosponsor two wellness programs being planned by William Hettler, MD, University Health Services, UW-Stevens Point, since SMS physicians had not been adequately involved in the planning process for the conferences.
- Agreed to do another promotional effort to SMS physicians regarding their use of the "Partners in Good Health" communications program begun last November. The Commission also will attempt to survey physicians as to the usefulness of the patient questionnaire included in the program.
- Reviewed results of the 1978 SMS Work Week of Health program stressing positive lifestyles which was aired over the Wisconsin Educational Television Network and beamed directly into the state's high schools. ■

Medical museum's future subject of membership poll

In January all SMS physicians were mailed an opinion survey regarding the Museum of Medical Progress at Prairie du Chien and its continued operation by the Society's Charitable, Educational and Scientific Foundation. Physicians were asked to state their opinions as to whether the Society should continue to operate the museum or turn it over to the City of Prairie du Chien, and how continued operation of the museum by SMS should be financed. Preliminary results of the poll will be given to the SMS Council at its February meeting. ■

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01); with plastic applicator, detachable label.

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Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of Dec 18, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

KENOSHA

De Guzman, Mariano F, 3618 8th Ave, Kenosha 53140 (1940, Regular, Pediatrics, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Bryant, David G, Madison, to 1128 Washington Ave, Oshkosh 54901

Cooper, Garrett A, Madison, to 301 Circulo De La Paladins, Green Valley, AZ 85614

Dean, James L, Madison, to 345 South 18th St, Sturgeon Bay 54235

Owen, Russell H, Madison, to Dept of Anesthesiology, 8700 W Wisconsin Ave, Milwaukee 53226

FOREST

Ovitz, Ernest G, Laona, to 730 McCall Rd, Englewood, FL 33533

KENOSHA

Ruehlman, David D, Kenosha, to 191 E El Camino Real, Mountain View, CA 94040

MILWAUKEE

Martin, Albert G, Milwaukee, to 8897 Midnight Pass Rd, Sarasota, FL 33581

DEATHS

Kehlnhofer, F H, Milwaukee County, Oct 24, 1978

Fletcher, Henry A, Milwaukee County, Nov 2, 1978

McAfee, George D, Eau Claire-Dunn-Pepin County, Nov 6, 1978

Galasinski, Roman E, Milwaukee County, Nov 17, 1978

Whereatt, Richard R, Manitowoc County, Nov 13, 1978

Backus, Edward A, Milwaukee County, Nov 26, 1978

Stauff, Glenn R, Brown County, Dec 4, 1978

Bercey, James E, Milwaukee County, Dec 11, 1978 ■

Membership Report as of Jan 3, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BARRON-WASHBURN-BURNETT

Damroth, Michael S, Rt. 3, Chetek 54728 (1944, Regular Family Physician, Certified)

CALUMET

Glenn, J H, 614 Memorial Dr, Chilton 53014 (1922, Regular, Pathology, Certified)

CHIPPEWA

Cook, Steven D, 2501 County Trunk I, Chippewa Falls 54729 (1952, Regular, Family Physician)

CLARK

Neelagaru, N, 1015 W 5th St, Neillsville 54456 (1949, Regular, Internal Medicine/Cardiovascular Diseases)

COLUMBIA-MARQUETTE-ADAMS

Esmaili, Muhammed, Box 10, Friendship 53934 (1942, Regular, General Surgery, Certified)

Hansell, Charles E, 410 South Lewis St, Columbus 53925 (1948, Regular, Family Physician, Certified)

Sankaran, R, Box 10, Friendship 53934 (1947, Regular, Pediatrics)

DANE

Crawford, David G, 2925 Fish Hatchery Rd, Madison 53713 (1950, Resident, Psychiatry)

Ebaugh, Duane W, 6211 Winnequah Rd, Monona 53716 (1938, Regular, Pediatrics, Certified)

Fisher-Beckfield, P, 4314 Tokay Blvd, Madison 53711 (1951, Resident, Internal Medicine)

Fliegel, Martin B, 4510 Regent St, Madison 53705 (1923, Regular, Child Psychiatry/Psychiatry, Certified-P)

Goodenough, David J, 6815 Century Ave, Middleton 53562 (1949, Resident, Neurology)

Hausserman, Sue A, 1300 University Ave, Madison 53706 (1946, Regular, Radiology, Certified)

Jensen, Norman M, 6210 Davenport Dr, Madison 53711 (1949, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)

Meyer, Charles T, 20 S Park St, Madison 53715 (1944, Regular, Psychiatry, Certified-P)

Schmelzer, Richard G, 5714 Odana Rd, Madison 53719 (1947, Regular, Family Physician)

Staley, Richard L, 657 Knickerbocker St, Madison 53711 (1945, Regular, Emergency Medicine)

DOOR-KEWAUNEE

Holmes, Ferrin C, 345 S 18th Ave, Sturgeon Bay 54235 (1942, Regular, Pediatrics, Certified-PD)

McFadden, Michael R, 345 S 18th Ave, Sturgeon Bay 54235 (1944, Regular, Urology)

Regehr, Edward H, 1304 First St, Kewaunee 54216 (1936, Regular, General Practice)

EAU CLAIRE-DUNN-PEPIN

Dow, C Thomas, 2600 Stein Blvd, Eau Claire 54701 (1948, Regular, Ophthalmology)

Hicks, Edgar O, 836 Richard Dr, Eau Claire 54701 (1947, Regular, Orthopedic Surgery)

Nordstrom, Charles R, 733 W Clairemont Ave, Eau Claire 54701 (1945, Regular, Gastroenterology/Internal Medicine, Certified-IM)

Pederson, Thomas E, 1030 Oak Ridge Dr, Eau Claire 54701 (1943, Regular, Ophthalmology)

Stenzel, Steven D, 2812 Marilyn Dr, Eau Claire 54701 (1948, Regular, Obstetrics and Gynecology)

GREEN

Chanbusarakum, P, 2709 Sixth St, Monroe 53566 (1947, Regular, Internal Medicine/Infectious Diseases, Certified-IM)

Thomas, R Buckland, 1515 10th St, Monroe 53566 (1931, Regular, Psychiatry, Certified)

GREEN LAKE-WAUSHARA

Raval, Mayuri P, RR #2, Box 99D, Berlin 54923 (1945, Regular, Pathology/Clinical Pathology, Certified-PTH)

Raval, Pinakin M, RR #2, Box 99D, Berlin 54923 (1943, Regular, Internal Medicine)

KENOSHA

Cohen-Levin, Ellen K, 6530 Sheridan Rd, Kenosha 53140 (1927, Regular, Psychiatry)

Ranieri, Rosanna M, 3618 8th Ave, Kenosha 53140 (1947, Regular, Internal Medicine/Neurology)

LACROSSE

Bathke, Dennis M, 1836 South Ave, LaCrosse 54601 (1947, Regular, Anesthesiology, Certified)

Davis, William E, 630 S 10th St, LaCrosse 54601 (1940, Regular, Family Practice, Certified)

MARINETTE-FLORENCE

Yuska, Kenneth H, 1421 Main St, Marinette 54143 (1945, Regular, Orthopedic Surgery, Certified)

MILWAUKEE

Aussem, John W, 2400 W Villard Ave, Milwaukee 53209 (1940, Regular, Pathology, Certified)

Beaver, Donald R, DO, 3531 W Burleigh St, Milwaukee 53210 (1933, Regular, Family Practice)

Bergin, Steven C, 10425 W North Ave, Wauwatosa 53226 (1946, Regular, Obstetrics and Gynecology)

Bushkell, Lawrence L, 5000 W National Ave, Wood 53193 (1945, Regular, Dermatology, Certified)

Cronin, Robert P, 4318 N Prospect Ave, Shorewood 53211 (1943, Regular, Radiology/General Practice, Certified-R)

Friedman, Robert H, 5141 N Marlborough Dr, Whitefish Bay 53217 (1942, Regular, Neurology/Psychiatry, Certified-P)

Fuhrmann, Donn D, 3175 S 28th St, Milwaukee 53215 (1950, Resident, Family Practice/Internal Medicine)

Inden, Ronald T, 14745 Watertown Pl Rd, Elm Grove 53122 (1945, Regular, General Surgery)

Jain, Dharam Pal, 2388 N Lake Dr, Milwaukee 53211 (1949, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)

Lubsey, Vincent G, 2711 W Wells St, Milwaukee 53208 (1943, Regular, Family Practice)

Mader, Michael H, 10425 North Ave, Wauwatosa 53226 (1947, Regular, Obstetrics and Gynecology)

Parent, Gerard T, 6745 W Wells St, Wauwatosa 53213 (1946, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)

Pugely, James M, 2388 N Lake Dr, Milwaukee 53211 (1947, Regular, Pediatrics/Allergy)

Recadio, Fred S, 1218 W Kilbourn Ave, Milwaukee 53233 (1946, Regular, General Surgery)

Schneider, George R, 9330 W Lincoln Ave, West Allis 53227 (1944, Regular, Internal Medicine, Certified)

Schulz, Caryn I, Box 257, Wood 53193 (1951, Resident, Dermatology)

Skibba, Joseph L, 610 N 19th St, Milwaukee 53233 (1940, Regular, General Surgery, Certified)

Suaverdez, Rudolfo P, 5631 W Lincoln Ave, West Allis 53219 (1939, Regular, Family Practice)

Tange, David B, 3015 N Cramer St, Milwaukee 53211 (1950, Regular, Internal Medicine)

Walsh, Patrick R, 8700 W Wisconsin Ave, Milwaukee 53226 (1948, Regular, Neurological Surgery)

Zach, James R, 2900 W Oklahoma Ave, Milwaukee 53215 (1950, Resident, Family Practice)

OUTAGAMIE

Barkmeier, John R, 2311 Hammond Ave, Appleton 54911 (1948, Regular, Family Practice)

Knoch, Frederick III, 445 Kittiver Ct, Neenah 54956 (1944, Regular, Emergency Medicine)

PIERCE-ST CROIX

Montemarano, V A, 7 Spring Cove Rd, Spruce and Spring, River Falls 54022 (1939, Regular, General Surgery)

POLK

Peterson, Timothy J, Oak Street, Frederic 54837 (1948, Regular, Family Practice, Certified)

PORTAGE

De Weerd, James H Jr, 2501 Main St, Stevens Point 54481 (1946, Regular, Orthopedic Surgery, Certified)

ROCK

Bennett, Paul II, 2618 E Collingswood Dr, Beloit 53511 (1934, Regular, Obstetrics and Gynecology)

Boyer, Richard P, 2020 E Milwaukee St, Janesville 53545 (1942, Regular, General Surgery/Emergency Medicine, Certified-GS)

Burandt, Donald C, 1905 Huebbe Parkway, Beloit 53511 (1935, Regular, Pediatrics, Certified)

Criswell, David K, 1905 Huebbe Parkway, Beloit 53511 (1933, Regular, Obstetrics and Gynecology)

Darrow, Gregory L, 2000 E Racine St, Janesville 53545 (1950, Regular, Family Practice, Certified)

Druckrey, Gerald R, 1905 Huebbe Parkway, Beloit 53511 (1933, Regular, Ophthalmology)

Fass, Steven J, 1905 Huebbe Parkway, Beloit 53511 (1946, Regular, Internal Medicine/Gastroenterology, Certified-IM)

Fossum, Jane F, 1905 Huebbe Parkway, Beloit 53511 (1945, Regular, Pediatrics)

Freemann, William S, 1905 Huebbe Parkway, Beloit 53511 (1925, Regular, Pediatrics, Certified)

Goelzer, Mark L, 2020 E Milwaukee St, Janesville 53545 (1949, Resident, Neurology)

Hebble, William M, 1905 Huebbe Parkway, Beloit 53511 (1935, Regular, Orthopedic Surgery, Certified)

Jhocson, Antonio L, 1905 Huebbe Parkway, Beloit 53511 (1939, Regular, Internal Medicine)

Lang, Thomas J, 1905 Huebbe Parkway, Beloit 53511 (1930, Regular, Internal Medicine)

Lee, Peter U, 1905 Huebbe Parkway, Beloit 53511 (1937, Regular, Otorhinolaryngology)

Lim, Roger G, 1905 Huebbe Parkway, Beloit 53511 (1938, Regular, Cardiovascular Diseases/Internal Medicine)

Meyer, Frederick N, 2020 E Milwaukee St, Janesville 53545 (1945, Regular, Orthopedic Surgery, Certified)

Miller, Edward C, 2020 E Milwaukee St, Janesville 53545 (1948, Regular, Obstetrics and Gynecology)

Miller, James R, 1905 Huebbe Parkway, Beloit 53511 (1945, Regular, Internal Medicine, Certified)

Ranola, Pedro O, 5 W Rollin, Edgerton 53534 (1943, Regular, Family Practice, Certified)

Spooner, Myron G, 1905 Huebbe Parkway, Beloit 53511 (1947, Regular, Obstetrics and Gynecology)

WALWORTH

Alabarca, Nestor C, 101 Broad St, Suite 202, Lake Geneva 53147 (1944, Regular, Internal Medicine/Pulmonary Diseases)

Seegers, James V, Walworth 53184 (1945, Regular, General Surgery)

WASHINGTON

Gupte, Uday V, 1113 E Sumner St, Hartford 53027 (1942, Regular, Internal Medicine/Gastroenterology, Certified-IM)

Weber, Eric F, 1004 E Sumner St, Hartford 53027 (1949, Regular, Internal Medicine)

WAUKESHA

Cherwenka, Richard W, 1100 Westbrooke Pkwy, Waukesha 53186 (1943, Regular, Anesthesiology)

Langenfield, Mark G, 1645 Legion Dr, Elm Grove 53122 (1945, Regular, Emergency Medicine)

Martinelli, Dean L, 888 Thackeray Trail, Oconomowoc 53066 (1945, Regular, Otorhinolaryngology, Certified-OTO)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Piper, Philip G, Madison, to 1000 Mineral Point Rd, Janesville 53545

MILWAUKEE

Cody, Edward F, Milwaukee, to 1200 North Center St, Beaver Dam 53916

SHEBOYGAN

Perez, Pablo M, Plymouth, to 716 Monroe St, Sheboygan Falls 53085

WAUKESHA

Barber, Jergen L, Waukesha, to PO Box 1877, Kalispell MT 59901

DEATHS

Rydell, Otto E, Barron-Washburn-Burnett County, Dec 18, 1978

Crottier, Charles J, Milwaukee County, Dec 25, 1978 ■

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The core of the Lithium Information Center is the Lithium Library, a comprehensive bibliographic computer data base of the medical literature dealing with lithium. The library currently contains over 4,500 citations, and is continually updated.

Physicians with specific patient problems, or anyone with a general question related to lithium may contact the Lithium Information Center for help. Examples of questions that have been asked include:

- ☐ Lithium use with children and adolescents
- ☐ Precautions during pregnancy
- ☐ Specific drug interactions
- ☐ Lithium-induced skin disorders
- ☐ Treatment of lithium-induced tremor
- ☐ Use with patients undergoing hemodialysis
- ☐ Cardiovascular side effects
- ☐ Lithium-induced weight gain

The Center responds to questions within 24 hours by providing computer printouts of relevant citations from the literature. All articles are on file in the Center, and arrangements may be made to provide copies when that does not infringe upon the new copyright laws.

The Center is a nonprofit organization funded partially by user fees; the minimum charge is $5.00, and the average charge is $7.50.

The Lithium Information Center, under the direction of Drs James W Jefferson and John H Greist, will expand its services this year with the development of a Lithium Consultation Computer Program. Physicians across the country will be able to consult on specific patient problems from a computer terminal located in their own practice setting.

Inquiries to the Lithium Information Center may be made by phone to the Information Specialist, Mr James Marcetich, at 608-263-6171, or by mail to: Lithium Information Center, Department of Psychiatry, University of Wisconsin, 600 Highland Avenue, Madison, WI 53706.

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Muzaffar Mirza, MD,* Friendship, recently was elected president of the Columbia-Marquette-Adams County Medical Society. Drs Victor Guzman Jr,* Portage, was elected president-elect and Frederick H Bronson,* Portage, was elected secretary-treasurer. Dr Robert T Cooney,* Portage, was elected delegate to the State Medical Society and Martin L Janssen, MD,* Adams, as alternate delegate.

James M Zarzynski, MD, Chippewa Falls, recently became a member of the medical staff of St Joseph's Hospital. Doctor Zarzynski graduated from the University of Wisconsin Medical School, Madison, and has taken over the medical facilities of Bruno F Rahn, MD,* who retired from active practice to become an emergency department physician at the hospital.

Henry Veit, MD* has retired from his private practice of psychiatry after 30 years in Milwaukee. He has moved to the Marinette area where he does part-time consultation in psychiatry at Marinette General and Menominee Lloyd hospitals. In recognition of his years of service, he has been appointed to the Honorary Staffs at St Luke's, Lutheran, and Family hospitals in Milwaukee. He also was appointed a Life Member of the Milwaukee Neuropsychiatric Society and a Life Fellow of the American Psychiatric Association.

James L Plos, MD,* Oshkosh, recently was elected president of the medical staff of Mercy Medical Center in Oshkosh. Other MDs elected were William A Crawford,* vice-president, and Richard C Hughes,* secretary. Department chiefs elected were Drs Edwin L Downing,* Department of Surgery; James L Basiliere,* Department of Medicine; and Richard C Wolfgram,* chief of the Department of Obstetrics-Gynecology.

Francisco Perez-Guerra, MD,* LaCrosse, has assumed the presidency of the medical staff of LaCrosse Lutheran Hospital, Doctor Perez-Guerra is a pulmonary disease specialist and has been with the medical staff since 1974. Drs James K Williams, chairman of the hospital's Emergency Medical and Trauma Center, is the vice-president; and Bruce A Polender,* internal medicine/allergic diseases, is the secretary-treasurer.

Walton R Manz, MD,* Eau Claire physician since 1930, recently received the University of Wisconsin, Eau Claire's "Distinguished Alumni Service Award." He has been chief of the medical staff and chief of surgery at Eau Claire's Sacred Heart Hospital and also on the medical staff of Eau Claire's Luther Hospital. Doctor Manz was a member of the Committee on School Health and a member of the Council of the State Medical Society.

David F Ruf, MD, Monroe, recently became associated with The Medical Center of Monroe SC medical staff. Doctor Ruf graduated from the University of Wisconsin Medical School in 1959 and has been in medical practice in Darlington since 1960.

Thomas W Miller, MD, Taylor Falls, formerly with the Indian Health Services in Cass Lake, Minn, has joined the medical staff of the St Croix Falls Clinic. Doctor Miller graduated from the University of Iowa Medical School and completed a three-year family physician residency in Ventura, Calif.

James A Halikas, MD, Mequon, associate professor of psychiatry and mental health sciences and director of the Division of Alcoholism and Chemical Dependency at the Medical College of Wisconsin, Milwaukee, has been appointed director of the Wisconsin Alcoholism and Drug Abuse Research Institute. The Institute recently was formed by MCW, the DePaul Rehabilitation Hospital, Milwaukee County Mental Health Center, the University of Wisconsin, Milwaukee, and the Wood Veterans Administration Center.

EDWARD J KERSCHER, MD* (above), physician at Euren in Kewaunee County for 65 years, again is thinking of retiring. At age 93, he is perhaps the oldest practicing physician in the United States. A Life Member of the State Medical Society, Doctor Kerscher stopped delivering babies at the age of 88; he has kept a record of each one, all 5,115 of them. Doctor Kerscher graduated from the University of Marquette School of Medicine in 1914. —Photo by *Green Bay Press-Gazette*

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PHYSICIAN BRIEFS . . .

Derward Lepley Jr, MD,* Elm Grove, is the new president of The Medical Society of Milwaukee County, and Walter Woloschek, MD,* Whitefish Bay, is the president-elect. Doctor Lepley is a clinical professor in the Department of Thoracic-Cardiovascular Surgery at the Medical College of Wisconsin. Doctor Woloschek is an associate clinical professor of surgery at the Medical College and also is a consultant at the Veterans Administration Hospital and St Mary's Hospital. William Finlayson, MD,* River Hills, was elected secretary-treasurer. He is president of the Milwaukee Gynecological Society and is a former president of the Cream City Medical Society. Doctor Woloschek will take office as president in January 1980.

Dean B Pratt, MD,* Sheboygan, was elected chief of the medical staff of Sheboygan Memorial Hospital and will serve a one-year term. Other MDs elected to serve with him were: Robert T Willis,* vice-president; and Martin Rammer,* secretary-treasurer. Doctor Pratt also will serve as chairman of the 13-member medical staff executive committee of the hospital.

John E Kippenhan, MD,* Cedarburg, has received an award for lifesaving efforts at an accident by the regional director of the State Patrol for the Fond du Lac County area. Doctor Kippenhan has been in family practice in Cedarburg for 21 years and also is on the medical staff of St Alphonsus Hospital in Port Washington. ■

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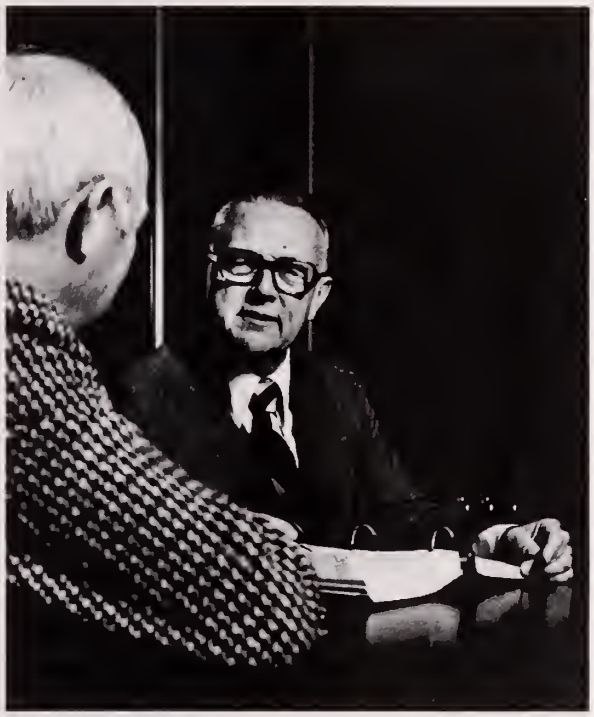

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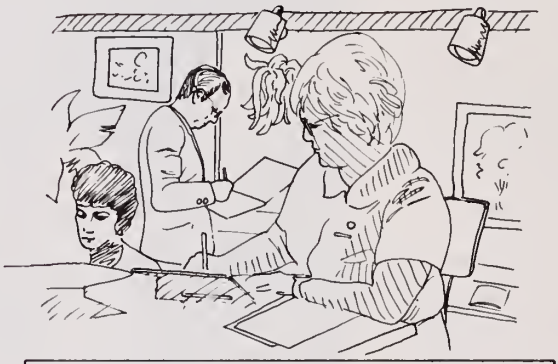

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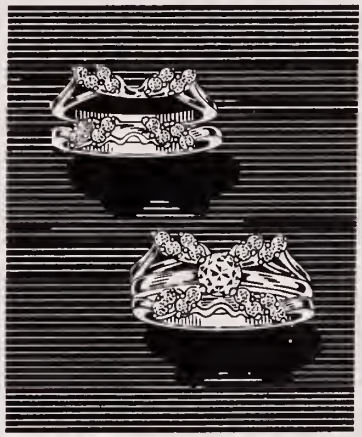

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NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service of the Middleton Health Sciences Library, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Hepatotrophic Factors, Ciba Foundation Symposium 55. CIBA Pharmaceutical Co, Division of CIBA-GEIGY Corp, Summit, NJ 07901. 1978. Pp 406.

Life, Love and Sex for Women in the Middle Years—The Second Season, by Estelle Fuchs, PhD. Anchor Press/Doubleday, Garden City, NY. 1978. Pp 298. Price: $3.95.

The Chemistry of Human Behavior, by Herbert L Meltzer, PhD. Nelson-Hall Publishers, 325 W Jackson Blvd, Chicago, IL 60606. 1978. Pp 261. Price: $17.95.

Natural Medicine, by Robert Thomson. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, NY 10020. 1978. Pp 329. Price: $10.95.

Fat and Thin—A Natural History of Obesity, by Anne Scott Beller. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1978. Pp 310. Price: $4.95.

Between You and Me, by John A Parrish, MD; Barbara A Gilchrest, MD, and Thomas B Fitzpatrick, MD. Little Brown and Company, 34 Beacon St, Boston, Mass 02106. 1978. Pp 238. Price: $8.95.

Functions of the Septo-Hippocampal System. Ciba Foundation Symposium 58. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, New Jersey 07901. 1978. Pp 437.

Major Mental Handicap: Methods and Costs of Prevention. Ciba Foundation Symposium 59. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, New Jersey 07901. 1978. Pp 226.

Chemosurgery: Microscopically Controlled Surgery for Skin Cancer, by Frederic E Mohs, BSc, MD. Charles C Thomas, Publisher, 301-327 East Lawrence Ave, Springfield, IL 62717. 1978. Pp 378. Price: $43.75. ■

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

American College of Cardiology (ACC) recently admitted the following Wisconsin physicians and surgeons to fellowship: MDs Louis C Bernhardt,* Neville Bittar, and Vincente U Yap, Madison; Kenneth A Geller* and Edward S Scanlan,* Menasha; and Gerald Dorros and Michael H Keelan, Jr of Milwaukee.

Milwaukee Academy of Medicine at its 93rd Annual Meeting held on Jan 16 has announced the following physicians as their officers for 1979. They are MDs Richard B Bourne,* president; Chesley P Erwin,* president-elect; Archebald Pequet,* vice-president; Thomas J Russell,* secretary; David J LaFond,* treasurer, and John P Mullooly,* librarian.

Marshfield Clinic held its annual meeting in January and elected Ben R Lawton, MD* once again as its president for the coming year. Doctor Lawton joined the Clinic in 1954. Joining Doctor Lawton as reelected or newly elected officers are MDs Nelson A Moffat,* vice-president; John P Parker,* secretary, and William J Maurer,* treasurer. Five other MDs were selected to complete the nine-person executive committee, and they are Gerald E Porter,* David F Bjarnason,* Paul S Treuhaft,* Frederic P Wesbrook,* and Cesar N Reyes.*

The Monroe Clinic officially celebrated its 40th anniversary January 1, and formal observance of the anniversary will be forthcoming later this year. The Clinic started in 1939 and included MDs Nathan E Bear,* W G Bear, W B Gnagi, John A Schindler, and Leurner E Creasy. Dr Nathan Bear, the last of the five founders, is retiring this year. The Clinic has grown to a total of 47 physicians, two optometrists, one clinical psychologist, and 171 employees. ■

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1979

2 Dane County Board of Trustees
4 SMS Committee on Mental Health
4 Subcommittee of SMS Committee on Maternal and Child Health
5 Fetal Alcohol Syndrome Work Group
8 Women's Health Issues Planning Committee
8 Dane County HMP Committee
9 SMS Committee on Aging
10 SMS Committee on Federal Legislation
10 SMS Commission on Governmental Affairs
10 SMS Committee on Environmental Health
10 WisPRO Criteria Committee
10 Work Week of Health Planning Committee
10 WisPRO Medical Care Evaluation Committee
11 WisPRO South Central District Review Council
11 Title 19 Oversight Committee
11 Subcommittee on Accreditation
11 SMS Commission on Peer Review
17 WisPRO Executive Committee and Board of Control
17 Wisconsin Review Foundation (WRF) Executive Committee
17 WisPRO Finance Committee
18 SMS Commission on Health Planning
18 Council of Professions
18 WHCRI Executive Committee
18 WisPRO Ancillary Services Review Committee
22 Women's Health Issues Planning Committee
25 SMS Committee on Medicine and Religion

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis. ■

1978 Blue Book Update

In the listing of County Medical Society presidents and secretaries, pages 89-91, the following changes have occurred:

CLARK: Ana C Capati, RFD 3, Box 257 Neillsville 54456 is president; and A Mitat Algan, 400 Mill St, Loyal 54446 is secretary.

DANE: J D Kabler, 1552 University Ave, Madison 53706 is president; William J Hisgen, 20 S Park St, Madison 53715 is secretary-treasurer. The president-elect is Hubert V Moss, Jr, 30 S Henry St, Madison 53703; and the vice president is David W Semian, 4824 Sherwood Rd, Madison 53711.

MANITOWOC: David D Pfaffenbach, 1119 Marshall St, PO Box 705, Manitowoc 54220 is president.

MARATHON: William C Miller, 808 Third St, Wausau 54401 is president.

ROCK: Walter A Scholten Jr, 1905 Huebbe Parkway, Beloit 53511 is the new president.

WALWORTH: Menandro Tavera, Jr, Rt 4, Box 126 Lake Geneva 53147 is president, and Edsel G Doreza, Kenosha St, Walworth 53184 is secretary.

WINNEBAGO: Charles R Lyons, 2000 East Murdock Ave, Oshkosh 54901 is secretary. ■

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Medical Yellow Pages

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Physicians Exchange

WANTED: INTERNIST INterested in cardiology for part-time work (15-35 hours/week) at the Bureau of Social Security Insurance, 310 Price Place, Madison, Wis 53705. If interested please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel: 608/266-1989. 2-5/79

SATELLITE POSITIONS AVAILable—Family practice opportunities available in satellite locations in farming and recreational communities with multispecialty clinic affiliation in east central Wisconsin. No investment. Complete tax-sheltered benefits and guaranteed first-year remuneration. Excellent hospital facilities. Contact Dept 456 in care of the Journal 5tfn/78

PHYSICIAN WANTED TO PERform light physicals five days per week in the Milwaukee area. Ideal job for retiring physician. Contact Mike Stough, collect, at 513/621-8728. 9tfn/77

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

PEDIATRIC, INTERNAL MEDIcine, Family Practice, Urology and ENT positions available with a multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 11-12/78;1-2/79

WISCONSIN, SHEBOYGAN — career oriented ED physician needed to help train and maintain hospital-based paramedic program. Flexible schedule with 20 days off each month. Superb recreational, educational, and cultural opportunities for physician and family in this city on the shores of Lake Michigan and adjacent to Milwaukee, Wis. 250-bed hospital with 10,000 patient visits per year. Remuneration: $63,300. Call or write Dr John Hron, ER Director, Sheboygan Memorial Hospital, Sheboygan, Wis 414/457-5033 or 414/377-9147. 2-4/79*

OB - GYN - PEDIATRIC OPENings in 12-man group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, PO Box 178, West Bend, Wis 53095. 11tfn/78

WANTED: TWO FAMILY PHYsicians preferably ABFP for association with the Family Medical Center, Sheboygan, Wisconsin. Please call or write: Martin A Rammer, MD, 1930 N 8th St, Sheboygan, Wis 53081; phone 414-457-5016. 5tfn/78

FAMILY PHYSICIAN: WAUSAU to join three board certified ABFP physicians. New medical office opened March 1978 and new hospital to open in 1979. Contact: R E Cadwell, MD, 212 Sturgeon Eddy Rd, Wausau, Wis 54401. Tel: 715-842-0491. 10tfn/78

FAMILY PHYSICIAN — O/B experience. Emergency Room Physician—July, August 1979. Opportunity for one of each in northern Wisconsin resort town of Eagle River. New clinic facility attached to hospital. Drawing area includes all of Vilas County, parts of Oneida, Forest, plus a large tourist and retirement population. If interested, contact: Charles E Reevs, Admin, Eagle River Memorial Hospital, Eagle River, Wis 54521. Tel: 715/479-7411. 1tfn/79

PSYCHIATRIST TO JOIN PRIvate psychiatric clinic with a family-oriented psychiatrist, psychologist, two certified social workers. Want conservative young man who enjoys work in psychiatric unit of general hospital and office practice in 40,000 pop city. Salary guaranteed up to $30,000 depending upon qualifications. Can get part ownership. 1½ hours from St. Paul-Minneapolis, good hunting, fishing, and winter sports. A A Lorenz, MD, 2125 Heights Drive, Eau Claire, Wis 54701. Tel: 715/834-3171. 2tfn/75

WISCONSIN, SHAWANO—SUperb opportunity for primary care physician to work in an ER and enjoy the recreation of northern Wisconsin. Only 30 miles from the Green Bay Packers. 100-bed community hospital with 8,500 annual ER visits. Remuneration: $66,240 for 10 days each month. Send resume or call Dr John Kirkpatrick, ER Director, Shawano Community Hospital, Shawano, Wis. 715/526-2111. 2-4/79*

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Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1979-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1979 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

1979 Wisconsin

Mar 4-6: Winter Pediatric Conference, sponsored by Marshfield Clinic Department of Pediatrics, at Powderhorn Ski Lodge, Bessemer, Mich. Info: H James Nickerson, MD, Chairman, Dept of Pediatrics, Marshfield Clinic, Marshfield, Wis 54449.

Mar 15: In-Depth Teaching Program, UW Center for Health Sciences, Madison.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835.

Apr 26: Regional Cancer Conference, Interlaken Lodge, Lake Geneva. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

May 3-5: Wisconsin Chapter: American Academy of Pediatrics, Pioneer Inn, Oshkosh, Wis 54901.

May 10-12: State Medical Society of Wisconsin Annual Meeting. MECCA and Marc Plaza, Milwaukee.

May 18-19: *Strabismus Symposium*-Special diagnostic techniques during the Mid-West Orthoptic Meeting. Concourse Hotel, Madison. 13 hours Category I credit. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706.

May 18-23: American Holistic Medical Association Annual Meeting, at University of Wisconsin, LaCrosse. Cosponsored by The American Society of Contemporary Medicine and Surgery. Forty hours of Category I CME credit. Info: AHMA, Route 2, Welsh Coulee, LaCrosse 54601.

June 1-2: *Medical and Surgical Corneal Disease.* North Central Regional Meeting, Eye Bank Association. Concourse Hotel, Madison. Category I credit available. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706.

June 7-8: Midwest Head and Neck Cancer Conference, State of the Art Program, Concourse Hotel, Madison. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

June 11-15: The Writing Workshop for MDs. Holiday Acres Resort, Rhinelander. Sponsored by UW-Extension. Info: Joe Eisele, Continuing Education Agent, UW-Extension Box 695, 1002 Coon St, Rhinelander, Wis 54501. Tel: 715/362-4093.

June 22-24: 31st Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians. The Abbey Resort, Fontana, Wis. 15 hours of CME and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove 53122.

July 29-Aug 1: The Second Annual *Nuclear Cardiology for the Practicing Physician* at Playboy Club Resort, Lake Geneva, Wis. Info: Dr Jagmeet S Soin, Division of Nuclear Medicine, The Milwaukee County Medical Complex/The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5968.

1979 Neighboring

Mar 5-8: *Neurology for the Internist,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Mar 7-9: Second National Meeting of the Nurses Association of the American College of Obstetricians and Gynecologists, Conrad Hilton Hotel, Chicago.

Mar 27-29: CME course: *Approaches to Clinical Problems in Gastroenterology and Hepatology,* sponsored by the University of Chicago Section of Gastroenterology and Liver Study Unit. At Center for Continuing Education, Chicago. Approved for 22 hours of Category I credit for AMA-PRA. Info: Sumner C Kraft, MD, Course Director, 950 E 59th St, Chicago, IL 60637. 1-2/79

Apr 6-7: *Medical and Surgical Problems in Infants, Children, and Adolescents* at Henry Ford Hospital, Detroit, MI. Audience: Pediatricians, Primary Care Physicians, General Surgeons, and Pediatric Surgeons. Fee: $150 Physicians; $75 Residents/Fellows; $25 Spouses. 15 hrs Category I of AMA/PRA. Contact: Henry Ford Hospital, Office of Medical Education, 2799 W Grand Blvd, Detroit, MI 48202. 313/876-1464. 2-3/79

HOSPITAL INFORMATION SYSTEMS SHARING GROUP

Spring meeting: May 16-18
Atlanta, Georgia

User-Oriented Systems —A Major Challenge

Fall meeting: Sept 19-21
Minneapolis, Minnesota

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Clair G Naylor, Chairman
HISSG Membership Committee
10 South Main Street, Suite 331
Salt Lake City, Utah 84101
(801) 531-1717

Apr 20: *How to help the hyperactive child,* a workshop at Menominee High School, Menominee, Mich. Sponsored by Bureau of University Services, School of Continuing Education and Community Services, Central Michigan University. Dr Marcel Kinsbourne, one of North America's leading authorities, will present his views as main speaker. He is director of the Learning Clinic, Hospital for Sick Children, Toronto, Ontario, Canada; and professor of pediatrics at the University of Toronto. Designed for parents, physicians, mental health personnel, educators, and others who desire to increase their understanding of hyperactive children and the place of the rational use of medication in their treatment. The topic is controversial and deserves further study. Basis for physician attendance: To interact with Dr Kinsbourne and to share your knowledge with parents and educators who attend. Fee: $30. Make check payable to Central Michigan University. Deadline for registration: April 7. Further info: Bureau of University Services, School of Continuing Education, Central Michigan University, Mt Pleasant, Mich 48859; phone 517/774-3715, ext 277. g2-3/79

UCLA Extension Department of Continuing Education in Health Sciences

Schedule of courses

Mar 10: *Proposals for a National Health Policy,* at The Beverly Hilton Hotel, 9876 Wilshire Blvd, Beverly Hills, CA. In cooperation with UCLA Schools of Medicine and Public Health, California Medical Association and the California Hospital Association. Fee: $95. Meets criteria for 6 credit hours in Category 1 of PRA-AMA.

Mar 10-11: *Prevention of Crisis in the Patient with Chronic Respiratory Disease,* at UCLA's Neuro-psychiatric Institute, 760 Westwood Plaza. In cooperation with UCLA School of Medicine and Lung Association of Los Angeles County. Approved for up to 12 hours of Category 1 credit toward PRA-AMA. Fee: $95 for physicians and $65 for health professionals.

Mar 14-18: *Seventh Annual Symposium on Vascular Surgery,* at The Canyon Hotel, Palm Springs, CA. In cooperation with the UCLA School of Medicine and The Society for Clinical Vascular Surgery. Meets criteria for 17 1/2 credit hours in Category 1 of PRA-AMA. Fee: $265 for physicians.

Info: Health Sciences, UCLA Extension, PO Box 24902, Los Angeles, CA 90024 or call 213/825-7186.

May 14-18: American Psychiatric Association. Conrad Hilton, Chicago, Ill. Info: M Sabshin, MD, 1700 18th St, NW, Washington, DC 20009.

May 16-18: *Cardiac Auscultation and Cardiac Examination,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar ACP, 4200 Pine St. Philadelphia, Pa 19104.

NATIONAL MEDICAL SPECIALTY SOCIETIES

1979 Meeting Dates/Sites

Mar 11-15: American College of Cardiology, Miami Beach, Fla. Info: William D Nelligan, Exec Dir, ACC, 9111 Old Georgetown Rd, Bethesda, Md 20014.

Mar 22-29: American Society of Clinical Pathologists and College of American Pathologists, New Orleans. Info: J L Normoyle, 2100 W Harrison St, Chicago, Ill 60612.

Mar 24-28: American Academy of Allergy, Hilton Hotel, New Orleans, La. Info: D L McNeil, Exec Dir, 611 E Wells St, Milwaukee, Wis 53202.

Mar 26-29: American College of Emergency Physicians, Del Monte Hyatt, Monterey, Calif. Info: A Auer, Exec Dir, 3900 Capital City Blvd, Lansing, Mich 48906.

Apr 2-5: American College of Surgeons, (Spring Meeting), Denver. Info: E Gerrish, MD, 55 E Erie St, Chicago, IL 60611.

Apr 26-29: Annual Meeting, American Society of Internal Medicine, New Orleans, La.

Apr 30-May 4: American Occupational Health Conference, Disneyland Hotel, Anaheim, Calif. Info: American Occupational Medical Association, Box P, 150 N Wacker Dr, Chicago, IL 60606.

May 13-17: American Urological Association, New York Hilton, New York. Info: R J Hannigan, Exec Sec, 4640 N Marine, Chicago, Ill 60640.

May 14-18: American Psychiatric Association, Conrad Hilton, Chicago, Ill. Info: M Sabshin, MD, 1700 18th St NW, Washington DC 20009.

May 23-26: American College of Sports Medicine, Honolulu, Hawaii. Info: ACSM, 1440 Monroe St, Madison, Wis 53706.

Sep 16-20: American College of Radiology, Chicago, Ill.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

News You Can Use

Mark your calendars for Health Planning Conference. The SMS Health Planning Commission announces it is sponsoring a major health planning conference in Madison on June 8 and 9. The conference is designed to give participants an overview of the health planning law, what the State Medical Society is doing to involve physicians in health planning through the Wisconsin Physicians Planning Network (WPPN), as well as an academic view of the need for health planning. Speakers will include individuals from state and federal governments, physicians actively involved in health planning, and local health planners. While the conference is aimed primarily at Wisconsin physicians, other interested persons are welcome to attend. For more information contact Neal Neuberger at the SMS Health Services Division in Madison at 1-608-257-6781 or toll-free: 1-800-362-9080.

Deadline extended for immunization promotion. The State Division of Health has announced that the immunization award program, due to end January 31, 1979 has been extended through October of 1979. The program features certificates that physicians and public health personnel can give to patients who are fully immunized against the major preventable childhood diseases. The certificates are redeemable for a free hamburger at any participating McDonalds Restaurant. Physicians, nurses, and other health-care personnel distributing the certificates are instructed to cross out the "January 31" date on the certificates and write or stamp "October 1979" in place of it.

Conference to explore women's health issues. The State Medical Society of Wisconsin and the Governor's Commission on the Status of Women are co-sponsoring a conference on women's health issues on April 23, 1979 in Madison. The theme of the conference is the sensitivity of the health-care system toward women. It is designed to educate participants about women's health issues; provide a setting where the health-care concerns of women may be voiced, as well as formulate recommendations regarding women's health issues to take to Wisconsin physicians at their Annual Meeting, May 10-12, in Milwaukee. Workshops will be held on such topics as women's rights and responsibilities as patients and citizens, birth control and unplanned pregnancy, maintaining health during pregnancy and childbirth, health in the middle and older years, alcohol and other drug abuse, mental health, and women and surgery. All interested persons are invited to attend; for more information contact the SMS Health Services Division in Madison; phone toll-free 1-800-362-9080.

DHSS says most pre-July physician claims now paid. The Department of Health and Social Services informed SMS that as of January 1, 99% of the pre-July 1, 1977 physician claims have been processed. The few remaining claims will take additional research and will require manual processing by the Department. DHSS will be checking its records for providers who previously received an advance payment against the total of payments made to the same provider by EDS Federal on the pre-July claims. Each provider or clinic will be informed by the Department as to the final figures of the advance compared to the actual amount paid. *Provider offices should do nothing until notified by DHSS regarding the advance payment/actual payment dollars.* Some physicians' offices have indicated that duplicate payments have been made on pre-July 1, 1977 claims. DHSS says it is aware that this could be happening in some isolated instances. It requests that the duplicate payment be refunded. It asks that refunds of these duplicate payments be sent to: EDS-Federal Corporation (REFUNDS), 6406 Bridge Rd, Madison, WI 53713. ■

STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

MARCH 1979

• Lose your license? You could, if . . . • Council proposes to modify unified membership rule • CPR special course for physicians • Things my mother never taught me • When a contract becomes an agreement • The impaired physician • Hypertension screening in central Wisconsin • Biosketches of nominees for SMS offices • Summary of resolutions to be introduced to SMS House of Delegates in May

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Front Page Update

Blue Cross-Blue Shield proposes reimbursement curbs. The Blue Cross and Blue Shield national associations expanded their Medical Necessity Project in February when they recommended that their combined 115 member plans: 1) pay for hospital "admission batteries" for medical patients only when specifically ordered by a physician, and 2) phase out routing payment for 26 diagnostic laboratory procedures now considered in their opinion outmoded, unnecessary, unreliable, or of no proven value. The Medical Necessity Project began in 1977 with a list of 42 surgical and diagnostic procedures considered to be of doubtful value. A spokesman for WPS in Madison said that it is going to "gather and review information prior to establishing a corporate position in Wisconsin." A Surgical Care spokesman in Milwaukee said it similarly will be working with physicians, hospitals, and other providers to determine the feasibility of the recommendation in Wisconsin, but added that Surgical Care "has generally accepted the directive from national Blue Cross-Blue Shield on the basis that it was done in consultation with the physician peer groups.

EDS Federal gets T-19 contract extension. The State Department of Health and Social Services has extended for one year EDS-Federal Corporation's contract to serve as fiscal intermediary for the State's Medical Assistance Program. Under the contract, EDS is responsible for processing and paying Medicaid (Title 19) claims for health care providers. Earl Thayer, secretary of the State Medical Society, said in an interview with the *Wisconsin State Journal* that Wisconsin physicians generally have been satisfied with the EDS record and the company's ability to clear up most of the pre-July 1 claims backlog. Robert Durkin, administrator for the State Division of Health, said the contract was extended for an additional year without competitive bidding because rebidding would have been too disruptive for the program. EDS-Federal took over the contract from Blue Cross-Blue Shield in July 1977.

Lose your license?

You could. . . if you fail to report your continuing medical education credits to the State Medical Examining Board by December 1, 1979. State law requires all licensed physicians to submit proof to the Board of 30 hours of Category I continuing medical education credit. Any physician failing to report CME credits by December 1, 1979 will not receive a license renewal notice for 1980-81.

Category I CME credits accumulated since January 1, 1977 can be reported. A receipt from the sponsoring organization indicating its name, your name, the number of hours completed, and Category I approval by either the AMA or the AOA is required. Proof of CME credits must be sent by December 1, 1979 to:

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1400 East Washington Avenue
Madison, Wisconsin 53703

. . . or you won't have a license to practice medicine in 1980. If you have questions or concerns, call the State Medical Society Health Services Division: 608/257-6781 (Madison area) or toll-free 1-800/362-9080. ■

STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

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State Medical Society of Wisconsin

STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841

Representing 4,600 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* the official publication of the Society.

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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Editorials

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Great expectations

At its meeting on February 3, 1979, the Council approved the following amendment to the Constitution of the State Medical Society:

> "This Society shall consist of members who shall be members of the component county medical societies, who have been certified to the headquarters of their Society, and all of whose dues and assessments for the current year have been received by the secretary." The amendment deletes the clause in Article IV which states: "and who shall also be members in good standing of the American Medical Association."

The amendment is to be introduced at the meeting of the SMS House of Delegates in May; and if passed, will do away with the much-maligned unified membership rule which makes membership in the AMA a requirement for membership in the State Society.

Council action was taken following tabulation of the unified membership poll conducted at the Council's direction late in 1978. Of the 2,589 responding, 1,440 (55.7%) opposed the unified membership rule. It must be noted, however, that in previous years also, sentiment seemed to indicate disenchantment with unified membership, right up until the meeting of the House of Delegates, but when the dust had settled and the meeting had adjourned, the unified membership rule remained in place.

Supporters of the amendment believe that nonmember physicians may find joining their County and State societies more to their liking if it isn't tied to AMA membership—that membership rolls in the State Society will grow, along with dues income, which will then permit the State Society to offer more services.

But what assurance is there that new members will apply in droves once they don't have to join that reactionary, conservative AMA any more? There really isn't any. Other state societies have failed to gain when the unified membership rule was dropped, and we probably will, too.

In the past failure to join because of objection to AMA policies has been a popular excuse, but it probably doesn't hold water. A more plausible reason is the up-to-$800.00 annual outlay required for membership dues if one is to belong to all three organizations. Some State Society officers maintain that if the AMA dues can be lopped off, the total will be more palatable—and that's true—but it still won't be as palatable as no dues at all, which is what those nonmembers are paying now. And there's the rub. Nonmembers may not have access to some of the services available to members if they stay out, but they do reap the major benefits of our political activities without spending a cent. It is doubtful that scrapping the unified membership rule will provide enough incentive to get them to invest $500 per year under those circumstances.—WJB

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Impaired physicians

Two years ago the State Medical Society of Wisconsin recognized the problem of the impaired physician and established a program to study and cope with it. In this issue are two relevant articles, one by Doctor Kempthorne who is chairman of the Society's Commission on Mediation and Professional Ethics, which is responsible for the program, and the other by Doctor Herrington who is the medical director of DePaul Rehabilitation Hospital in Milwaukee.

Wisconsin physicians are urged to read these two articles and to participate in the panel discussion at the State Medical Society's Annual Meeting in Milwaukee in May. There also will be an exhibit at the same meeting.

It is commendable that the State Medical Society has become a leader in the problem of the impaired physician and has set up the program to deal with it. It is prudent that this has been brought out into the open instead of trying to whitewash or hide a tragic situation. This may be a painful procedure at times, but as the *Milwaukee Journal* editorial pointed out, this should be seen as a welcome approach.—VSF ■

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- Rapidly relieves pain and itching

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
CAUTION: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2.25%, bismuth resorcin compound, 1.75%, benzyl benzoate, 1.2%, Peruvian balsam, 1.8%, zinc oxide, 11.0%, also contains the following inactive ingredients bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg. also contains the following inactive ingredients propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery

Anusol-HC Cream is also indicated for pruritus ani

Anusol-HC is especially indicated when inflammation is present After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants

Anusol-HC is not for ophthalmic use

Dosage and Administration: Anusol-HC Suppositories—Adults Remove foil wrapper and insert suppository into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides Then maintain patient comfort with regular Anusol Suppositories

Anusol-HC Cream—Adults After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure Then squeeze the tube to deliver medication Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment

NOTE If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24), in silver foil strips with Anusol-HC W/C printed in black

Anusol-HC Cream—one-ounce tube (N 0047-0090-01), with plastic applicator, detachable label

Store between 15°-30° C (59°-86° F)

Full information is available on request

Warner/Chilcott
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Opinion/Dialogue

CME: "What's the gripe?"

HARDLY A WEEK goes by without some journal arriving at my desk with an editorial decrying the principles or practice of the Continuing Medical Education (CME) concept. "We shouldn't have to do this" they say, and others bemoan the cost of the programs, both as regards to registration fees and time lost from the office and practice. "I didn't learn a thing" they say, and call the programs "a university ripoff by the ivory tower boys" or "AMA sucker bucks."

Let's look at the facts.

—*The immediate problem* is this: The documentation of efforts at "keeping up" is *the mandate of the law of the land!* The Department of Health, Education, and Welfare (HEW) has stated that there must be a documentation that the individual physician is making an effort to maintain his knowledge and skills at a level commensurate with what is felt to be a high standard throughout the country. Now more than 20 states have incorporated CME activity into the requirements for relicensure and it will likely become uniform throughout the 50 states. No use arguing about it; the law is here.

—*How reasonable is the demand?* Very reasonable, I say, when one stops to reflect on the burgeoning of medical knowledge and skills over the past 20 years. Whole new concepts of disease entities, diagnostic and treatment modalities have evolved in the past 10 years, and we all have problems trying to handle the numerous journals that cross our desk. Additionally, we are living in a different era than that of 25 years ago, when a physician's word was not questioned. *Consumer groups* are now questioning and demanding answers, realizing that physicians are humans and that the pressures of their lives and professions may not have allowed them to keep up with the latest. Consumerism is here and we must adjust. *Ethically* we are committed to CME by virtue of the awesome responsibility we have in caring for life itself. *Practically* the responsible physician has been fulfilling these mandates anyway, so that it now offers no new responsibility. But, sad to say, that is not true of all of us, and at times it seems that those who need it most are those who cry the loudest.

—As to the clamor about *costs,* I remind the complainer that the fees and expenses are for the most part *deductible.* Granted, we lose a few gross dollars by being absent from our practice for a time, but as a rule, the change of pace is refreshing; and furthermore, who can set a price on a clear conscience?

—The *role of the university* and large hospital is equally clear. Hopefully, therein are the teachers and therein are the specialty-trained physicians who have the indepth knowledge of the smaller areas of general medicine we may need help with. They should be able to do the teaching job well as that is part of their mandate. The fees that are charged are largest from those institutions which traditionally enjoy a good reputation for research and teaching. In charging larger fees, they are practicing one of our American heritages, the principle of free enterprise. If we really don't like it, we really don't have to patronize them. Certainly there are ample means provided for *local hospitals* becoming accredited to sponsor their own CME-accredited programs, if their staff qualifications and energies will allow. In this way CME credits can be accumulated with a minimal expenditure of time and money, if that is desired.

—To those who decry the AMA for its role in furthering CME, I say isn't it better that we do it ourselves rather than wait for the government to intervene even more? We are the AMA, and its experience in medical education goes back to 1905 with its Council on Medical Education and Hospitals. It seems certain that the AMA has greater insight into our needs than a bureaucratic layman.

So what's the gripe?—The need is there as a sign of the times and as a law. The mechanism of obtaining the credits is reasonable, and the costs are deductible. Who knows, perhaps one day the information a colleague gains at a CME course will help him do a better job caring for one of us. Who knows?—Learn and enjoy!

PHILIP J DOUGHERTY, MD
Menomonee Falls ■

President's Page

President: JULES D LEVIN, MD
State Medical Society of Wisconsin

Things my mother never taught me

THE WORLD IS FULL of unrest. Society does not lack for change. Yet change does not necessarily imply *progress*. And progress is not always change for the better.

My dear mother, of sacred memory, taught me many things to better prepare me for the continuing change in this nebulous world. But she did not teach me that politics makes the world go round, that politically appointed bureaucrats and *not* duly elected congressmen and legislators run the country, that these pseudo-intellectuals create multitudes of rules and regulations which have the power of law by fiat, that bureaucrats go on forever, without recourse to either citizen or politician. My mother did not tell me that Mr Califano would usurp the power of the medical school faculty: I have just learned that I may now again start to perform lobotomies, because Mr Califano said that it was alright to do them. My mother did not tell me that the bureaucrats and their *Federal Register* would replace the *Pharmacopia*. My mother did not tell me that the bureaucrat's philosophy was that a socialistic and egolitarian government is best for the United States. I merely have the gut feeling that the people who think they know it all bother those few of us who really do!

Many problems plague the physician and the medical profession today.

Internal dissention is perhaps one of the greatest curses of organized medicine. Perhaps because of, or in spite of, the fact that we are an intelligent, knowledgable, highly trained group of rugged individualists, there is so much in-fighting and bickering and dissention that we have been nominated as the professional group most likely to commit hari-kiri. We spend our energies in folly and bankrupt our emotional reserves. As Pogo said so well, "We have met the enemy, and they is us!" We are indeed our worst enemy. In our petty emotional harangues we miss the most important issue of the day: The relentless advancing tide of progressive governmental control of the practice of medicine. We are being trapped between inflation and the bureaucracy and are allowing ourselves to be stampeded into disorganization, disarray and weakness. We are ready victims of the old technique of divide and conquer. Alone, each of us has a feeble voice and can accomplish but little. Together, we can be heard as a thunderbolt and make an impact. To paraphrase the venerable Hillel, "If we are not for ourselves, then who is for us?" We can and must utilize our effort and energy, our personal commitment and responsibility by becoming actively involved in the politics of medicine at all levels: locally at the hospital medical staff and the county society level, then at the state and the national and the specialty society levels. We must pledge our energy and our fortunes to the survival of the free and unfettered practice of medicine as we know it. Would that we had the confidence, the loyalty and the respect for our profession that was so characteristic of the physician of old! Would that we could measure the behavior and the activity of our daily lives in the light of the betterment of the profession, rather than in the individual economic gains to ourselves. So much does affluence rule our behavior and our very lives that we oft forget that we are forging our history for posterity and so will they judge us. I have been asked on occasion why I spend so much energy in the medical society activity, and I recount the biblical allegory of the old man and the calaba tree. An elder gentleman was planting a number of calaba trees. Knowing that such trees mature for some 40-50 years before bearing fruit, a youth passing by asked the elder gentleman whether he thought he would live to harvest the fruit of the trees. His answer was, "I did not plant the trees whose fruit I harvest."

When did criticism of medicine and the profession begin? Surely it began with the inception of medical insurance, with Medicare and Medicaid, with the rapid acceleration of medical science and technology, with the rising costs of

medical care, and with the rising affluence of physicians. And with these rising costs came the clamor in society and the recognition in the law for greater utilization of pseudo-scientific cults. There has been a similar and parallel effort on the part of some paramedical groups to gain recognition as independent medical practitioners. The entire current drama is reminiscent of the rise of the so-called "barefoot doctors" of the Peoples Republic of China several decades ago. The late Chairman Mao quickly realized that there was no possible way of supplying medical care to the 800 million Chinese with the relative handful of scientific physicians available in China at the time. He therefore gathered all the herbalists, cultists, acupuncturists, pseudo-scientific therapists and allied quacks in the healing arts, gave them all an intensive short course in first-aid and sent them forth into the realm as the new doctors of China, supplying "medical care" to all. Medicine, as practiced in China today, is one-third scientific, one-third cultist-herbalist, and one-third Mao political philosophy. If current trends in America persist and if Senator Kennedy has his way, we will quickly pass from a state of excellent medical care for most citizens to a state of very mediocre medical care for all.

The cost of medical care remains as perhaps the most urgent problem before the House of Medicine today.

Health care accounts for 8.4% of the Gross National Product here in America. But who has decided that 8.4% of the Gross National Product is an adequate amount to allocate for health care and who has decided that an estimated 10% of the Gross National Product, predicted for the year 1982, will be a much too great an amount to spend for the health of Americans? Those same individuals have decided that 11.5% is not too much to spend for alcohol, tobacco and entertainment, that 21% of the Gross National Product is not too much to spend for defense, that something more than 40% of the Gross National Product is not too much to spend on government costs. Perhaps it is high time that we rearrange our priorities!

A few months ago in Chicago, members of the House of Delegates of the American Medical Association debated a number of important issues.

The problem of chiropractic has a way of being a chronic annoyance to us. There are several litigations pending against the AMA and all physicians in general. By way of background, be aware that the AMA policy on chiropractic has not changed, but the law of the land has changed! Chiropractors are licensed in all 50 states and are entitled by law to practice whatever they are allowed to do without interference. Any organized group, be it a hospital medical staff, a county medical society, a state medical society or the AMA, who adopts a position that it is unethical for their members to accept patients from a chiropractor, would be in direct violation of the Sherman Anti-trust Act. Two separate and distinct litigations are now pending against the House of Medicine as regards the chiropractors:

1) The suits in New Jersey and Pennsylvania ask only that chiropractors be granted access to laboratory and x-ray facilities at hospitals and to receive reports of the same. The litigations allege conspiracy by the House of Medicine to deny chiropractors access to such, inspite of laws that give them the legal right to such access. The agreed upon settlement in the Pennsylvania suit states simply that specialists, specifically radiologists and pathologists, ethically may choose to accept or decline patients sent to them by chiropractors. Section 3 of the Principles of Medical Ethics of the AMA states, "A physician should practice a method of healing founded on a scientific basis. He should not voluntarily associate professionally with anyone who violates this principle." However, Section 4 of the same Code of Ethics requires a physician to obey all the laws. The great problem and confusion that exists here rests on the fact that with today's laws, the tenets of the Code of Ethics are contradictory. Resolution of this problem is the core of dissention and disagreement within the ranks of medicine. Section 5 of the Code of Ethics states that, "A physician may choose whom he will serve." The law permits the individual physician to exercise that freedom. However, groups of physicians, such as medical staffs or medical societies, making that same choice together, no longer constitutes the exercise of freedom of individual choice, but is in fact a conspiracy. The law views a hospital medical staff as a group of physicians and they may not conspire. If radiologists or pathologists are self-employed, they have freedom of choice as to whom they serve. But if they are employed by a hospital, they cannot refuse to take an x-ray or perform a lab test when requested by a chiropractor. An interesting sidelight here in Wisconsin relates to the assumption of chiropractors that they are allowed by law to draw blood for samples. The State Medical Society of Wisconsin has long taken issue with this assumption and now the State Medical Examining Board has issued a declaration that chiropractors may not puncture

skin for diagnostic or therapeutic purposes without being charged with the practice of medicine without a license.

2) The second chiropractic suit, versus the AMA and the House of Medicine, has a much broader base. The suit alleges conspiracy on the part of medicine to monopolize health care service and unreasonably restrain licensed chiropractors from competing in the delivery of health care services; the suit further alleges that the House of Medicine is trying to eliminate chiropractic by adopting and enforcing statements that label chiropractors as unscientific cult and a hazard to the health of the public. On this issue the AMA is determined to stand firm: chiropractic is an unscientific cult. This issue we will fight in the courts and in the halls of legislatures!

The Federal Trade Commission, in keeping with its bureaucratic character, has recently assumed the powers of accuser, prosecutor, and judge. It has decided that medical societies are organizations primarily interested in the profit motivations of their members and therefore come under the surveillance of the Commission. An FTC judge has recently ruled against the New Haven County Medical Society, the Connecticut State Medical Society, and the AMA holding that these medical societies have restrained physician advertising and physician participation in alternate forms of health care delivery systems. The real threat of the new ruling, however, is that it prohibits all medical societies from establishing guidelines in ethics for two years and then only after receiving permission from the FTC to do so. Furthermore, the medical societies, and especially the AMA, must serve as police arms to inform the FTC of infractions of the law by these societies. The result of this bureaucratic law by fiat has far-reaching implications in all professions. The AMA will fight this law tooth and nail, by suit, by appeal, even to the United States Supreme Court and via legislation in the halls of Congress. The irony of the matter rests in the fact that it will cost hundreds of thousands of dollars for medicine to pursue this litigation and we will be opposed by an army of lawyers whose salaries in the FTC come out of our tax monies!

Another thorn in the soft under-belly of medicine is the problem of the so-called "unnecessary surgery." I am as confused by the term as I was at the sign in the personnel office at the local industrial plant which read, "Please list all employees broken down by sex." "Unnecessary surgery" is a controversial issue that has generated much more publicity and misunderstanding than it deserves. I recognize three categories of surgical procedures:

1) Emergency surgery, sometimes referred to as necessary surgery.
2) Discretionary surgery, defined as surgery which would tend to improve the quality of life and the state of wellness of the body.
3) Inappropriate surgery, or irresponsible surgery, that which really should not be done.

Time is the critical distinction between emergency surgery and elective surgery. I do not doubt that there is some unnecessary surgery, just as there is unnecessary journalism, unnecessary bureaucracy, unnecessary politics, and especially unnecessary governmental regulations. The greater and more important problem is not whether there is unnecessary surgery, but how great and how significant is the problem. The concept of consultation or the so-called second opinion has been heralded by the naive bureaucrat and politician as the unmistakable criterion of surgical necessity and has been duly exploited for their own neferious purposes. The entire medical profession recognizes that "second opinions" are merely a method of measuring differences of opinion and do not in themselves represent an accurate method of determining the necessity of surgery. A difference of opinion between the consultant and the original surgeon does not equate with exploitative nor irresponsible surgery. Dr Ralph S Emerson, renowned New York surgeon, magnificently noted: "The United States Supreme Court is comprised of highly qualified jurists, but they usually have a difference of opinion and it is most unusual to have a unanimous decision. This is because the laws are not precise and are subject to interpretation and a difference of opinion. To imply that the jurist who disagrees is always right would be highly improper in law." Yet some of our so-called respected politicians and bureaucrats want us to believe that this philosophy and mechanism is perfectly right in medicine. This obvious dishonesty has been widely publicized as gospel in the press. It has been said that the Devil can quote Scripture for his purposes and so have the politicians done.

My admonition to you is that you take seriously the threat of government and its relentless assault on the practice of medicine. Do not be lulled to inactivity by your present affluence. Unless you join together, work together, and fight together, unless you pledge your energies and your fortunes, the practice of medicine as we know it today will soon vanish. ■

In Perspective

Editor: BRIAN JENSEN
Director, Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

When a contract becomes an agreement

SEVERAL WEEKS AGO the Physicians Alliance Commission and the Council of the State Medical Society approved what is hoped to be a giant step toward avoiding future "contractural" problems in the Medicaid program in Wisconsin. These two physician groups endorsed the wording of a new provider "agreement" designed to take the place of the infamous T-19 contract issued by the State Department of Health and Social Services last summer.

For several months the Staff of the Physicians Alliance Division and the special T-19 Oversight Committee of the PA Commission had reviewed both state and federal laws and regulations which mandate the need for some form of agreement between state Medicaid agencies and the various providers of services in the program. That review was one of the more comprehensive and exhaustive studies of federal law conducted by the Physicians Alliance Division in my brief three-year stint with the Division.

The Social Security Act as amended through 1976 has required the use of provider "agreements" with state Medicaid agencies and has been one element of continual HEW criticism of the Wisconsin Medical Assistance Program (WMAP). HEW audits of 1976 through 1978 have reportedly chastised DHSS for its failure to initiate such agreements.

What the Alliance study revealed, however, was that the latitude available to state MA agencies regarding the content and format of such agreements is as wide as the Social Security Act itself. The Act clearly requires agreements; the placement of that agreement whether on the claim form utilized by the state agency and its fiscal intermediary or as a separate document remains the province of the state. The only federal requirement for *content* is that the agreement or its component administrative implementation must require the provider to retain adequate records regarding the services or items provided to the recipient patient and that such records must be available to the state Medicaid agency or the Secretary of HEW. Needless to say, those minimum requirements are a far cry from the extensive three-page contract distributed by DHSS last year. To be sure, state Medicaid agencies may *add* items to the agreements, but HEW only requires these minimums.

The value of the Alliance study of the federal law and implementing regulations was that for one of the few times in our dealings with DHSS, the Alliance Staff of three, assigned to this project, was better prepared and more knowledgable about *federal* T-19 requirements that the DHSS "Staff of dozens." The Department wasted little time in accepting the Alliance interpretation that the WMAP could practically write any type of agreement . . . as long as an agreement was written. This was complemented by the fact that all of the "favorable" provisions of the 1978 contract have been absorbed into the drafts of the MA "Super-Rule."

Therefore, the Title 19 "contract" has now become a Title 19 "agreement" effective in conjunction with the promulgation of the Super-Rule on July 1, 1979. The Alliance Commission and the SMS Council carefully and wisely pointed out that physician acceptance of the new "agreement" should be contingent upon a favorable disposition of the final draft of the Super-Rule. The new agreement is very brief—only two sections covering less than half a page—and 1) requires providers to comply with all state and federal laws regarding the WMAP, and 2) that the Department agrees to reimburse providers according to the "terms of reimbursement" attached to the agreement. If the major policies of the WMAP change or the reimbursement methodology is changed, this new agreement is null and void.

What this change—from contract to an agreement—simply means is that the physician agrees to provide services and the Department agrees to pay for those services. The details of WMAP policies and procedures, rights and responsibilities

IN PERSPECTIVE welcomes reader comment on political, legislative, or socio-economic concerns facing physicians.

of both provider and recipient, etc will be contained in the final draft of the Super-Rule. Because of this fact, physicians are urged to watch for Physicians Alliance communications regarding the Super-Rule; to fail to do so may mean another long, hot summer of confusion, high emotions, and an inappropriate expenditure of time and energy.—BRIAN JENSEN ■

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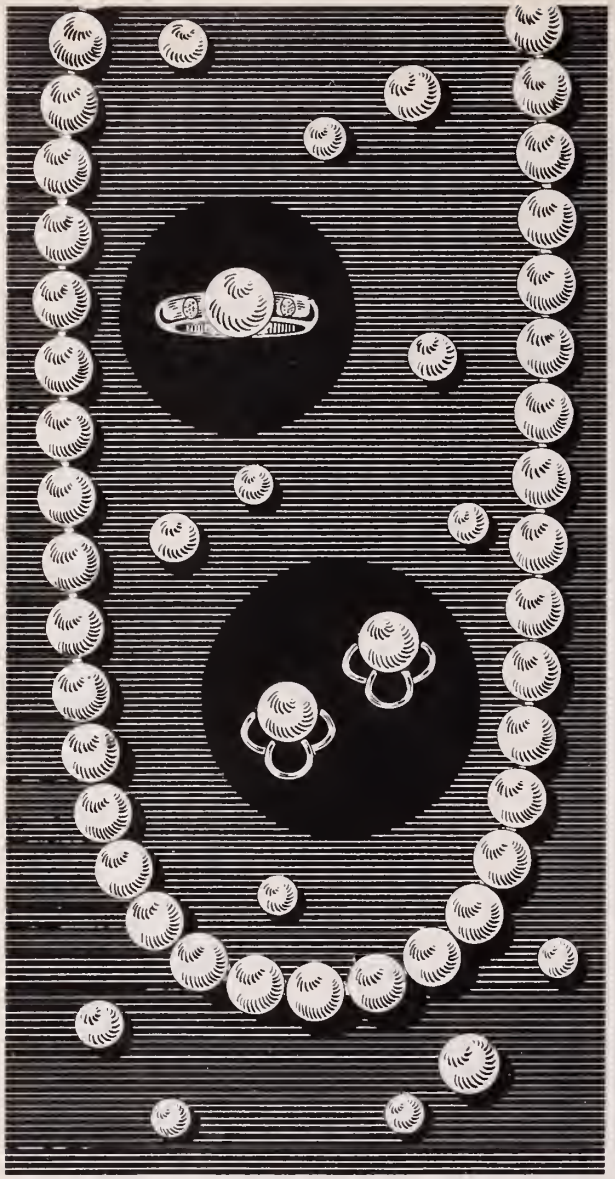

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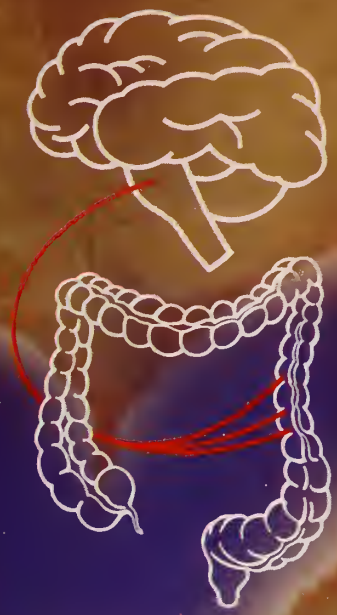

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Mediation
Professional Ethics

Editor: DOUG NELSON
Director, Health Services Division

The impaired physician – Recognition, diagnosis, and treatment

Roland E Herrington, MD, Milwaukee, Wisconsin

Impairment of a physician's performance as a healer and as a professional person in the community, by alcoholism, drug dependency, or mental illness, is not a new problem. What is new, however, is a better feel for the extent of the problem, as well as the kinds of impairment seen.

Table 1 illustrates the striking typology. Alcoholism and other drug dependency account for 85% of all physician impairment.[1] This figure is bolstered by such findings as an increased physician death rate from liver cirrhosis;[2] 40% of physician suicides being alcohol or drug-related,[3] and over representation of physicians in the federal narcotic hospital in Lexington.[4]

The exact incidence of chemical dependency in physicians is not known, but at the national level it is often estimated that between 10% and 15% of physicians are in some state of alcoholism or other drug addiction.[5] Thus Wisconsin, with 6,000 physicians, could potentially have between 600 and 900 physicians suffering from some degree of chemical dependency. The need to help our fellow physicians is obvious and stems from our sense of collegiality and public responsibility.

The reasons for the high incidence of chemical dependency are not totally clear. Alcoholism and other drug addiction appears to be an occupational hazard related to the physician's lifestyle, as well as to psychological problems having their origins in early life. The physician whose only interest is the practice of medicine, and who experiences a minimum amount of gratification from family and recreational activities, seems particularly vulnerable to the excursions into drug use. Access to narcotic and sedative drugs is another factor predisposing to chemical solutions for personal or professional problems. Still others blame pressures during training and the responsibilities and frustrations of medical practice.

The diagnosis of alcoholism in physicians is largely in the middle or late stages of the disease. Narcotic addiction is more likely to be detected earlier because of legal difficulties associated with drug procurement. This generally means the physician has been involved with pathological drinking or drug use, with its attendant disabilities, for

Table 1

The impaired physician—10-15% of all physicians

Mental Illness	*Chemical dependency (Alcholism and other drug dependency)*
15%	85%
1. Affective disorders Unipolar Bipolar	1. 90% Alcoholism*
2. Neurosis—Most often depressive type	2. 10% Drug addiction a. Narcotics—especially meperidine b. Sedatives c. Stimulants
3. Schizophrenia	*3. Percentage of alcoholic physicians dependent on other drugs estimated 30-50%
4. Senility	

Doctor Herrington is Medical Director, DePaul Rehabilitation Hospital, Milwaukee. Reprint requests to State Medical Society of Wisconsin, Impaired Physician Program, PO Box 1109, Madison, Wis 53701. Copyright 1979 by the State Medical Society of Wisconsin.

"Alcoholism and other drug dependency account for 85% of all physician impairment . . . (At the national level) it is often estimated that between 10% and 15% of physicians are in some state of alcoholism or other drug addiction. Thus Wisconsin, with 6,000 physicians, could potentially have between 600 and 900 physicians suffering from some degree of chemical dependency. The need to help our fellow physicians is obvious and stems from our sense of collegiality and public responsibility . . . Alcoholism and drug addiction appear to be occupational hazards related to the physician's lifestyle, as well as to psychological problems having their origins in early life . . . Awareness of chemical dependency in ourselves and in our colleagues offers hope of early recognition and successful treatment . . . Success depends on many factors, but accurate diagnosis, individualized treatment, proper monitoring, family therapy, Alcoholics Anonymous, including International Doctors in Alcoholics Anonymous, Narcotics Anonymous, and assisted re-entry into medical practice are among the most important (in the full-recovery process)."

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a period of several years. These are years of grave danger for the physician, his family, and his patients.

The social disabilities of the chemical dependency syndrome relate to marital problems, high divorce rates, adjustment difficulties in the children, and increasing isolation from peers and friends.

Professionally, the impairment may be seen in erratic behavior signaled by wide mood swings and altercations with hospital or clinic personnel as well as patients. The chemically dependent physician may fail adequately to follow his hospital caseload because of inability to respond at the proper time. This impairment is much worsened by such related complications as blackouts and acute brain syndromes due to intoxication or withdrawal states. In the beginning the signs are subtle and may be noticed only by close family members and a few peers. Most often there is denial that anything is wrong by both family and fellow physicians, leading to a cover-up and an excuse system not unlike that experienced by the addicted physician. Additional signs may include changes in the physician's handwriting, deteriorating performance in medical records, poorly explained trauma from falling while intoxicated, and a variety of other accidents. A striking finding is a general decrease in self-discipline, such as failure to keep appointments and a seeming indifference to this. A decrease in productivity is also detectable in later stages.

The physical disabilities are often dealt with by colleagues in a well-meaning but destructive cover-up of the underlying alcohol or drug dependency syndrome. One example of this is the physician admitted to the hospital to sleep off a drunk under the guise of treating "hypertension." The net effect of this failure to confront the problem is to enable the person to continue dependent, allowing for further physical, mental, social and professional deterioration. This problem is far more likely to occur when ethyl alcohol is the drug. Many physicians do not view alcohol as a drug, even though it is one of the most toxic psychoactive substances ingested by man. That many physicians think there is no problem is, in fact, a large part of the problem. Awareness of chemical dependency in ourselves and in our colleagues offers hope of early recognition and successful treatment.

The recognition of chemical dependency in a colleague calls for an enlightened confrontation. The medical model provides the most appropriate and effective setting to accomplish this goal. The evidence for the presence of the chemical dependency syndrome should be carefully explained to the physician patient. The disabilities related to the syndrome will be found in physical, mental, and social spheres. Corroborating or supporting laboratory data also should be included. This is accomplished in an emphatic and nonjudgmental way. The physician patient will most often offer a large variety of excuses and explanations for these findings, often blaming a family member or colleague for a series of events which he feels resulted in his excessive use of alcohol or other drugs. This is part of the delusional system of addiction and is very real to the physician patient. Outright denial after a carefully executed confrontation is uncommon, but minimization with the statement, "I will take care of it myself," is in our experience, the most frequent response to initial confrontation. It is essential at this point to involve the spouse, older children, and close friends in a firm display of loving concern which surrounds the physician with the reality of his or her situation. Consultation with a physician experienced in the diagnosis and treatment of chemical dependency can materially assist in the recruitment of the physician into treatment. Referral to the State Medical Society's Impaired Physician Program or to County Medical Society Programs as they develop (see accompanying article by Doctor Kempthorne), is appropriate if resistance to treatment is experienced. These Programs utilize panels of knowledgeable physicians, some of whom have had personal experience with

chemical dependency. This type of additional confrontation usually achieves a "voluntary" enlistment in a long term recovery program. The results of such a confrontation are usually good. Should continued resistance to treatment and the recovery program be encountered, the Medical Examining Board may need to be involved. This Board is a very important resource in the recalcitrant case, and offers protection to the public, as well as significant motivation to the addicted physician to complete the recovery process.

The importance of accurate early diagnosis of chemical dependency can hardly be overstated. The Criteria for the Diagnosis of Alcoholism, as set forth by the Criteria Committee of the National Council on Alcoholism in 1972 are helpful. Similarly, the summary report of the World Health Organization Group of Investigators on Criteria for Identifying and Classifying Disabilities Related to Alcohol Consumption[7] gives particularly good insight into the nature of the alcohol dependency syndrome. This model, with slight modifications, is useful in understanding misuse of other mood-altering drugs. Physicians have tended to concentrate on the physical, mental and social disabilities of alcohol and other drug abuse, while ignoring the underlying dependence syndrome. The diagnostic problem is somewhat more difficult in the physician because of the high incidence of multiple drug involvement and the interactions which may exist between these substances.

The differential diagnosis must always include the possibility of the presence of a major psychiatric syndrome with alcoholism or other drug dependency. Failure to identify and adequately treat psychiatrically these problems generally portends a poor result. Conversely, the treatment of a major psychiatric syndrome with alcohol addiction, without treating the alcoholism is usually not successful. Treatment of both conditions is often beneficial.

A major factor in the early diagnosis and treatment of the addicted physician is the status of the physician's family. In addition to the usual family dynamics seen in alcoholism, there is often substance abuse of some kind present in the spouse or children. Long term success of the physician is best achieved by dealing concomitantly with these problems early. Professional help should be sought through a recognized treatment facility. Alanon and Family Anonymous groups should be strongly advised and supported.

The full recovery process requires between three and five years. Great strides are usually made in the first year, following complete abstinence from all mood-altering drugs. Inpatient rehabilitation treatment is an intense introduction to continuing treatment, with subsequent outpatient care required for a period of at least two years. Success depends on many factors, but accurate diagnosis, individualized treatment, proper monitoring, family therapy, Alcoholics Anonymous, including International Doctors in Alcoholics Anonymous, Narcotics Anonymous, and assisted re-entry into medical practice are among the most important. Physicians generally have workable psychological problems, good support systems, and considerable intellectual and social skills. Recovery rates, with proper treatment, should be very high. Studies by Talbott and others support this contention.[8]

DOCTORS, like everyone else, are not immune to alcoholism, drug addiction, or mental illness. All too often, however, their afflictions have been hidden or denied. That helps no one. And it can hurt many, including the ailing physician, his or her family, and patients—even other doctors. The State Medical Society's new Impaired Physician Program is a welcome effort to deal more forthrightly with doctors who have problems. Questions involving a doctor's professional competence and ethics can be sticky. But to ignore them is to court tragedy, possibly resulting in revocation of the doctor's license. Then the reputation and credibility of the entire medical profession can suffer. The new program allows a personal, immediate, and direct response to reported problems . . . The thrust of the program is compassionate intervention to help doctors in the grip of human failings recognize and admit their problems and get assistance. All doctors should welcome this approach to a long neglected problem. So should their patients.—Editorial in the *Milwaukee Journal*, July 25, 1977.

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The impaired physician—The role of the State Medical Society

Gerald C Kempthorne, MD, Spring Green, Wisconsin

In June 1977 the State Medical Society of Wisconsin established an Impaired Physician Program to help the doctor suffering from alcoholism, other drug dependency, or mental illness. The Society's Commission on Mediation and Professional Ethics was designated to serve as the focal point for any problems involving an allegedly impaired physician.

The Commission developed a protocol describing the manner by which it conducts the Impaired Physician Program. Briefly, when a physician is reported to the Commission as being impaired, the complaint is validated by State Medical Society staff as well as the Commission. The complaint, or request for assistance, may come from the physician himself, a colleague, hospital official, family member, or patient. After validation the impaired physician is confronted by a colleague on the Commission and one other person with experience in the field of the physician's impairment. The entire experience is undertaken in an atmosphere of compassion, understanding, and complete confidentiality.

Through experience the Commission feels that the confrontation aspect is very crucial and must proceed with a colleague-to-colleague, compassionate atmosphere. The punitive approach is rarely successful. If the physician is recalcitrant and rejects confrontation efforts of his colleagues, it may be necessary to refer the impaired physician to the Medical Examining Board. However, the majority of physicians referred to this program have accepted the compassionate, rehabilitative approach and have responded to recommendations for treatment.

The physician is urged to enter a program of treatment to remedy his impairment. If the physician agrees to the rehabilitative program, the Commission will assist in finding a treatment facility. The Commission will continue to monitor the physician's treatment program which is not considered completed until the facility can report to the Commission with some assurance that the physician is ready to resume his/her practice.

The Commission emphasizes that the range of impairment includes alcoholism, other drug dependency, senility, and other physical and mental disorders. In the State Medical Society's opinion impairment extends broadly beyond the realm of alcoholism despite the fact that it may appear to be the major problem.

In the experience of members of the Commission on Mediation and Professional Ethics, it has been found that many problems of impairment can be handled at the hospital medical staff level. Most physicians belong to hospital medical staffs which generally are closely knit and well organized. Many early signs of impairment are recognized initially at the medical staff level. The Commission has found that the larger medical staffs are more successful in handling impairment and related problems of incompetence. However, the Commission has noted that at times smaller medical

"Through experience the Commission (on Mediation and Professional Ethics) feels that the confrontation aspect is very crucial and must proceed with a colleague-to-colleague, compassionate atmosphere. The punitive approach is rarely successful."

Doctor Kempthorne is Chairman, Commission on Mediation and Professional Ethics, State Medical Society of Wisconsin. Reprint requests to: State Medical Society of Wisconsin, Impaired Physician Program, PO Box 1109, Madison, Wis 53701. Copyright 1979 by the State Medical Society of Wisconsin.

staffs find it difficult to handle such problems. The State Medical Society is ready and willing to assist any hospital medical staff, any physician, or respond to any citizen of Wisconsin when alerted to a physician impairment situation.

The State Medical Society, through its Commission on Mediation and Professional Ethics, recognizes the importance of prevention and education of the impaired physician problem and to the importance of referral to available treatment facilities such as DePaul Rehabilitation Hospital, Milwaukee Psychiatric Hospital, St Mary's Hill Hospital, and Ivanhoe Sanitarium in Milwaukee, and Hazelden Treatment Center in Center City, Minnesota. A number of general hospitals throughout Wisconsin also are equipped to handle acute stays.

Impairment can start early in the physician's career for a variety of reasons as explained by Doctor Herrington in the accompanying article. The Commission believes that early recognition and early confrontation are most essential in the expeditious handling of impairment problems before they affect patient care.

Because the impaired physician in Wisconsin appears to be a substantial problem, the State Medical Society of Wisconsin has taken a strong leadership role in the direction of an educational program. For the first time a major panel discussion on the impaired physician will be presented at the State Medical Society's Annual Meeting, May 10-12, in Milwaukee. The panel's subject matter and participants were selected to give visibility to the problem generally and to emphasize the urgent need for Wisconsin physicians to take timely and effective action to identify and assist their impaired colleagues.

In addition to the panel discussion at the Society's Annual Meeting, an exhibit will be developed and staffed by physicians who are experienced in the areas of impairment and treatment. These physicians will be available for discussion with colleagues in attendance at the Annual Meeting. They also will be able to recommend treatment facilities with successful records in rehabilitating physicians with impairments.

It is hoped these two efforts—the panel discussion and exhibit on the impaired physician —will alert physicians and other Wisconsin citizens to the nature of the problem and ways and means to remedy it. These efforts also will assist the Society substantially in encouraging those physicians with impairment problems to accept and undertake recommended therapy or rehabilitation.

When an impairment problem is suspected, the Society urges all physicians and other interested parties to consult the Commission on Mediation and Professional Ethics through the SMS Health Services Division staff at its headquarters in Madison. The State Medical Society maintains a toll-free number for use in any legitimate situation. That number is: 1-800-362-9080.

The State Medical Society recognizes that its Impaired Physician Program is the only statewide voluntary group charged with this responsibility. However, The Medical Society of Milwaukee County for a number of years has had a Physician Welfare Committee which has successfully assisted several impaired physicians. More recently the Milwaukee Society created an Impaired Physicians Loan Fund to provide temporary financial support to physicians in need during the rehabilitation process. Other county medical societies have begun discussions on creation of programs to aid impaired physicians.

The State Medical Society of Wisconsin welcomes this responsibility and urges participation by anyone who wishes to consult the Society on matters involving impairment. ■

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Key words: Proteinuria, childhood diseases, renal disorders

Etiology and evaluation of proteinuria in children

Russell W Chesney, MD and **Aaron Friedman, MD**
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THE SIGNIFICANCE OF proteinuria found on a routine urinanalysis is often uncertain, since this may be a transient finding or related to a serious renal or systemic disorder. Proteinuria is a laboratory finding not indicative of a single disease. Accordingly, the type of evaluation indicated is not clear cut.[1] This discussion concerns proteinuria in children. Attention is focused on the pathophysiology, etiology, and evaluation of this finding.

Urine from healthy individuals always contains some protein. A small amount of protein is filtered through the glomeruli and incompletely reabsorbed by the tubules. This results in the finding in normals of a protein excretion of 100 mg per m^2 surface area per 24 hr.[2] The child who is six to eight years of age should excrete no more than 100 mg and an adult no more than 200 mg daily. Since the quantity of protein excreted increases with age, the finding of proteinuria in an isolated urine specimen is more likely in the older child or adolescent.[2]

Protein is ordinarily confined to the glomerular capillary by three barriers: (1) a positive-charged material coating the fenestrations along the capillary wall, thus retarding transit of predominantly large cellular elements or highly charged proteins; (2) the basement membrane with its "effective" pore size of 60 Å in diameter which retains most high molecular weight proteins; and finally (3) the slit diaphragm between epithelial foot processes.[2,3] This diaphragm is coated with a highly charged sialoprotein and is the ultimate barrier to the passage of protein molecules greater than 44 Å in diameter. Net charge in the sialoprotein forms the basic hindrance to the passage of charged protein molecules.[3] The loss of this charged sialic acid layer probably leads to the proteinuria found in certain glomerular disorders.[4] This complex barrier within the glomerulus is highly effective; since of the 40 to 50 gm protein entering both renal arteries each minute, only 1-2 mg appear within the tubular lumen. Fully 90% of this filtered protein is reabsorbed by proximal tubule epithelial cells and only 100 to 200 mg of the 25,000 gm of protein entering the kidney daily are lost into the urine.

Proteinuria may be either transient, orthostatic, or fixed.[5] Although the relative frequency of each type is unknown, transient proteinuria is probably the most common. Transient proteinuria may occur following heavy exercise, emotional stress, or extreme cold. In addition, increased protein excretion is found in approximately 5% of hospitalized children having a temperature of greater than 38.4 C.[6] In each of these instances proteinuria disappears hours to days later. The cause of this proteinuria is unknown, but has been

From the Pediatric Renal Disease Clinic, University of Wisconsin-Madison Center for Health Sciences. Reprint requests to: Russell W Chesney, MD, Department of Pediatrics, UW-Madison Center for Health Sciences, 600 Highland Ave, Madison, Wis 53792. This study supported by NIH Grant AM-19489. Copyright 1979 by the State Medical Society of Wisconsin.

Table 1—Glomerular disorders in children leading to proteinuria

Physiologic, exercise, fever or postural
Nephrotic syndrome: minimal lesion, membranous, membrano-proliferative, focal sclerosing
Hereditary nephritis
Acute glomerulonephritis: post-streptococcal or viral (infectious mononucleosis or mumps)
Immune complex nephritis: lupus nephritis, with infected ventriculoatrial shunts, syphilis, hepatitis B antigen, or after subacute bacterial endocarditis
Diabetes mellitus
Hypertension, malignant
Membrano-proliferative glomerulonephritis
Henoch-Schönlein purpura
Chronic undifferentiated glomerulonephritis
Rapidly progressive glomerulonephritis (anti-glomerular basement membrane antibodies)
Lipodystrophy with glomerulonephritis

ascribed to changes in the state of hydration, plasma volume, epinephrine release, or renal blood flow.

Orthostatic proteinuria refers to the finding of protein in urine specimens collected after the assumption of the upright position, but not found during recumbency or overnight. A dip stick test may often reveal a 2 to 3+ reaction in urine samples collected during the day, but a quantitative 24-hr protein excretion is usually less than 1.0 gm. To date, most long-term studies of subjects with postural proteinuria have revealed no progression to uremia, despite persistence of intermittent proteinuria for a period of years.[7] Minor abnormalities of glomerular morphology may be found on renal biopsy.[8] The cause of this orthostatic exaggeration of protein excretion is unknown, since normally more protein appears in the urine during the night when renal blood flow is greater.

Fixed proteinuria, present on multiple urine examinations without postural exaggeration, may be indicative of more serious glomerular disease (Table 1). Occasionally persistent proteinuria may be entirely asymptomatic and have a benign course.[9] Other disorders such as chronic pyelonephritis, chronic interstitial nephritis, renal dysplasia, and hydronephrosis may demonstrate some proteinuria (Table 2), but usually less than 1.0 gm per 24 hr. In various renal tubular disorders proteinuria may occur, but the proteins excreted are of a molecular weight smaller than albumin (MW 69,000) and are designated tubular proteins. Proteins such as B-2 microglobulin (MW 11,000) and lysozyme (MW 14,000) are representative examples. Tubular proteinuria is seldom in excess of 1.0 to 1.5 gm per day.

Patients with chronic glomerulonephritis of any cause usually have the combination of proteinuria and hematuria with red cell casts evident on urine

Table 2—Renal tubular disorders leading to proteinuria

Cystinosis	Analgesic nephropathy
Fanconi syndrome	Heavy metal poisoning
Bence-Jones proteinuria (myeloma or amyloidosis)	Chronic pyelonephritis
Sarcoidosis	Chronic interstitial nephritis
Vitamin D toxicity	Renal tubular acidosis
Medullary cystic disease	Renal transplantation

microscopy, but proteinuria alone is occasionally encountered in patients with membranoproliferative glomerulonephritis or membranous nephropathy.

The standard methods of testing for proteinuria are: (1) test reagent strips, (2) 3% sulfosalicyclic acid, or (3) heat and acetic acid. However, the astute clinician will often notice a foamy appearance to urine when it is shaken. The test reagent strips (Ames Laboratories) are impregnated with tetrabromphenol blue which is highly sensitive, but tends to detect albumin more than other proteins. These strips detect protein quantities as low as 20-30 mg/dl and may actually demonstrate the levels of protein found in urine from normal individuals. In addition, false positive tests may be found in a highly alkaline urine or in the presence of quartenary ammonium compounds found with infection. Further, these sticks should be fresh and the cap on the bottle containing sticks tightly sealed; discolored sticks may give inaccurate results.

The sulfosalicyclic acid method is highly sensitive, but not as sensitive as the dip stick method. Urine turbidity, indicative of proteinuria, will often clear upon heating when tubular protein is present, but persists with heating when glomerular proteins are present. The quantity of protein present is directly related to the extent of turbidity after an equal volume of 3% sulfosalicyclic acid is added. If the urine is so turbid that one cannot read through the test tube, then it represents 2+ proteinuria (~100-200 mg/dl). Clumps of whitish precipitates represents 4+ proteinuria (~1000 mg/dl). The major source of false-positive results is the presence of high concentrations of penicillin in the tested urine.

The time honored technique for the detection of proteinuria is heating the sample in a Bunsen burner flame and then adding a few drops of glacial acetic acid. As in the sulfosalicyclic acid method, the turbidity found represents acid denaturation of the urinary protein. If no turbidity is present after acid treatment or the use of test strips, one can be certain that no urinary protein is present.

Whenever proteinuria is detected, an evaluation of the cause should be undertaken.[10] Reexam-

ination of the urine after a few days to weeks should eliminate transient proteinuria. If proteinuria is found on two or three examinations, a test for orthostatic proteinuria should be made. Before retiring, the patient should empty his/her bladder. The first morning urine, collected on rising, should be saved, as well as a urine after the patient has been erect for at least two hours. Assumption of a lordotic posture may accentuate the quantity of protein excreted. If the first urine is devoid of protein, and subsequent samples contain protein, the diagnosis of orthostatic proteinuria is established.

If protein is found in every urine, a 24-hour collection should be made for protein quantitation. If tubular proteinuria is suspected, a radioimmunoassay kit for β-2 microglobulins (Pharmacia Diagnostics) is available for confirmation. Measurement of the serum concentrations of creatinine, cholesterol, albumin, and the third component of complement (C'3 or B_1C-globulin) may assist in diagnosis. Further potentially useful studies include a urine culture (since a urinary tract infection may result in increased protein excretion) and an intravenous pyelogram. Should proteinuria persist or if hematuria and red cell casts are also detected, a renal biopsy is probably indicated. The published studies in children in the *British Medical Journal* have shown that the clinical pathologic correlations between proteinuria and the significant changes in the renal biopsy are more significant if the patient is excreting more than 2 gm of protein per 24 hours.

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Abstracts

Management of sudden coronary death

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Ann Thoracic Surg 24:337-345 (Oct) 1977

Up to 47 percent of survivors of out-of-hospital sudden coronary death (SCD) without myocardial infarction experience a second episode within two years of the first. Twenty-three survivors of such episodes were followed after initial hospitalization, cardiac catheterization, and coronary angiography at the Milwaukee County Medical Center. Ultimately, 11 had coronary revascularization, and 12 were followed medically. Advanced coronary disease was prevalent in both groups, as evidenced by a history of previous myocardial infarction (MI) in 10 patients, triple coronary artery disease in 20, and ventricular dysfunction in 21. Selection for revascularization was not randomized, but was based on precarious coronary anatomy, and was reinforced by post SCD ventricular dysrhythmias and angina. At the time of the initial report, average follow-up was 13 months. There was one preoperative death from low cardiac output in a patient not operated by the authors, and one death one week postoperatively from recurrent ventricular fibrillation (all four grafts were patent at autopsy, and there was no fresh infarction). There were three medical deaths (two recurrent SCDs), a mortality rate of 25 percent. Since publication of the original paper, four additional patients have had revascularization with no deaths, so that operative mortality in patients operated by the authors is now seven percent (1/14).

Our current approach to the SCD survivor is as follows: Patients without evidence of new MI are catheterized in the hospital or soon after discharge. Patients with new MI are catheterized within the first three months. Patients with angina, positive stress tests, or intractable ventricular arrhythmias are offered operation on the basis of symptoms alone, if their coronary anatomy permits. In addition, operation is offered to all patients with precarious coronary anatomy regardless of other factors. ■

Refer to: Wallis WM, Larsen RB: Hypertension screening in central Wisconsin—A Ward Ford Memorial Institute. *Wisconsin Med J* 78:29-31 (Mar) 1979

Key words: Hypertension screening, preventive medicine, community health

Hypertension screening in central Wisconsin —A Ward Ford Memorial Institute

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• The results of hypertension screening in an industrial and rural agricultural area are presented. Fifty percent of the sample showed normal readings with a negative personal history, while eight percent had normal readings but a positive family history. Of these, fifty-one percent had at one time been on antihypertensive medication and thirty-six percent were currently taking medication. Fifty-two percent stated that one or more of their parents had been hypertensive. Forty-two percent of the sample showed an initial positive reading and thirty percent of these were on medication. Forty-two percent had a history of hypertension in one or both parents. It should be emphasized that followup examinations are necessary to evaluate the significance of an initial solitary elevation.

HYPERTENSION MAY BE considered as singularly well adapted to mass screening techniques for the following reasons:

1. The initial period during which the patient may be asymptomatic makes it unlikely that he will seek a physician's care early in the course of the disease.[1]

2. A single, simple noninvasive technique (arm blood pressure determination with the sphygmomanometer) may be easily taught to paramedical personnel and may be performed quickly with minimum inconvenience to the subject. While a single determination is not diagnostic it will single out a group that will require further attention.

3. Treatment is available that, if properly supervised, will satisfactorily control systolic and diastolic levels in the majority of cases.

4. Control of pressure may prevent or delay the onset of renal, cerebral, or cardiac complications.[1,2]

During a two-and-a-half-year period (May 1975 to November 1977) some 30,000 individuals were screened for hypertension by the A Ward Ford Memorial Institute, and of this number data from 12,093 were analyzed during a 14-month period. Although the literature is replete with blood pressure screening surveys,[2-11] this study is perhaps unique in that it is almost entirely an all white population with primarily German and Polish background and comprising a mixture of agricultural and industrial occupations. The screening was conducted in the north-central area of Wisconsin (Marathon County). The instruments for the screening were developed via a pilot project in a large industry employing sedentary workers, and these instruments were designed to be used in any type of industrial or public screening. The questionnaires* consisted of a two-part series. Part I was completed by all those being screened and Part II was completed by those screened who indicated a positive personal history or a blood pressure elevation. The criterion for evaluation was a reading above 140/90 mm Hg. A positive personal history consisted of an affirmative answer to at least one of the following questions:

1. Have you ever been told you have high blood pressure?
2. Have you ever been on medication for high blood pressure?
3. Are you now on medication for high blood pressure?

Ms Wallis is Coordinator of Health Occupations, Mid-State Technical Institute, Marshfield; and Hypertension Screening Director (past), A Ward Ford Memorial Institute, Wausau. Doctor Larsen is Medical Director, Employers Insurance of Wausau, Wausau, and Medical Director (past), A Ward Ford Memorial Institute, Wausau. This study was made possible by grants from: A Ward Ford Memorial Institute, The United Way of Marathon County, and The Florence and John Schumann Foundation. Publication support provided. Reprint requests to: Ellet H Drake, MD, Medical Director, A Ward Ford Memorial Institute, Wausau Hospital North, Wausau, Wis 54401. Copyright 1979 by the State Medical Society of Wisconsin.

*The questionnaires (Parts I, II, and III) are available from the authors.

The blood pressure readings were taken on both sides with the person seated with arms resting at heart level. The first and fifth Korotkoff sounds were used. Each individual was given an explanation of the significance of blood pressure as well as individualized health teaching relating to cardiac risk factors particularly hypertension.

Level of referral was obviously an individualized situation as were the criteria for the number of re-checks. Age, family history, risk factors, and lifestyle were some of the factors examined to determine the feasibility of referral. Cross checks (using different machines) were done on all who had what was considered to be a dangerously high reading. In addition, each employee who registered an elevation or borderline reading was given the time and date of public screening sessions which are held monthly throughout the city.

Cooperation was solicited from the labor unions who were kept informed of all screening activities in the area. Likewise, management groups in industries were contacted about the screenings. It was stressed to all that the information was strictly confidential and the screening program strictly voluntary. Only the nurse in the industry would have access to the employee's blood pressure readings as she would be doing the followup checks. The nurse used her own judgment regarding the number of re-checks before physician referral and made the decision as to whether a referral was indicated. A questionnaire,* Part III, was sent to the doctor with those patients who were referred. The form, to be completed by the physician, was returned to the company nurse and indicated to her the course of action the physician wished her to follow in regard to his hypertensive patients. Figure 1 shows the referral results of four large industries. To date, employees in over 250 industries have been screened, representing every type of occupation from the sedentary to the heavy duty construction worker. Cooperation from all industries was excellent including the granting of permission for employees to be screened on company time. One industry did a cost analysis of the screening. This company, employing 760 individuals (of whom 518 were screened) tabulated the employees' time at the screening as well as the re-checks, nurses' overtime at screening and re-checks, printed material, and new blood pressure equipment. The total cost was $301.03, demonstrating that screening is a most economical example of preventive medicine.[9,12]

The 12,093 individuals whose information was tabulated were divided into three groups: those with positive readings, those with negative readings, and those with negative readings but a positive personal history. Those with positive readings numbered 5,013 (42%), the negative readings numbered 6,125 (50%), and those with negative readings and positive history numbered 955 (8%).

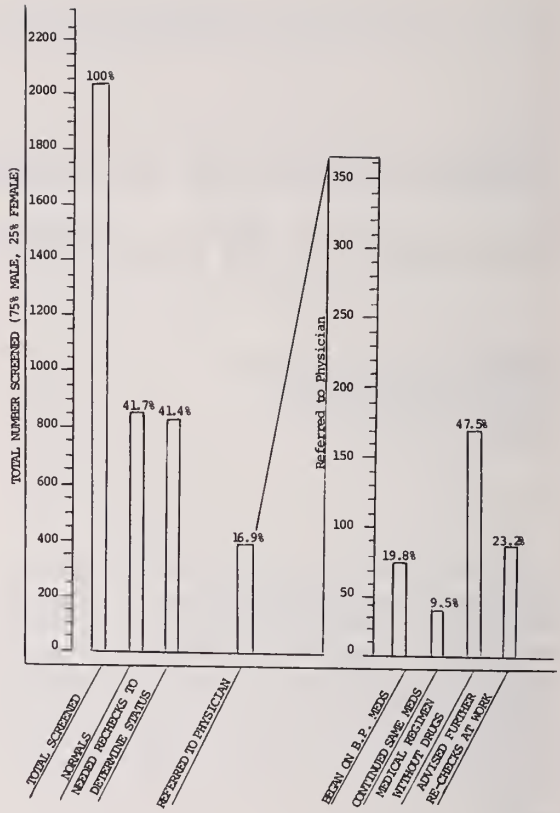

FIGURE 1—Results of industrial screening and referral.

Normal blood pressure with positive history. All 955 persons stated that they had been told at one time that they were hypertensive although only 486 (51%) had ever been on antihypertension medication and 340 (36%) were currently on medication. Thirty-eight people (4%) stated they had smoked at one time but had quit, 287 (30%) still were smoking, and 152 (16%) claimed they smoked over a pack of cigarettes a day. One hundred thirty-three (14%) stated that they had been diagnosed at some point as having heart trouble, but the nature of the problem was not disclosed. In questions relating to the parental history, 52 percent stated that their parents have or had high blood pressure with 40 percent answering "no" and 8 percent stating they did not know. When asked questions about parents having had diabetes, kidney disease, stroke, or heart trouble, 65 percent answered "no" in all cases. Of the 955 who registered normal readings, but had a positive history, 344 (36%) were currently on

medication, although a total of 487 (51%) indicated they had at some time been on antihypertensive medication.

Positive readings. Only 2,249 of the 5,013 (45%) had ever been told they were hypertensive, and only 1,517 (30%) had ever been on medication for it, with 1,153 (23%) currently on hypertensive medication. At all ages, more females had been treated with medication for their elevated pressures; *eg*, in the age group below 20, 52 percent of the females had been treated as opposed to 30 percent of the males. The percentage of both sexes falls dramatically in 20-29 age group and gradually rises to the seventh decade. Less than 4 percent were diabetic. Smoking was not a factor, and half of those who stated they had smoked at some time had given it up. Five hundred sixty-two (11%) had been diagnosed as having some kind of heart trouble, but the nature of the heart problem was not disclosed. Forty-two percent had history of hypertension in one or both parents. There was nothing of significance with parental history relating to diabetes, kidney disease, stroke, or heart trouble.

Over half of those with initial single positive tests were unaware of any previous suspicion of hypertension (55% against 27.7% with CHEC—Community Hypertension Evaluation Clinic). Seven hundred and thirty-two of those previously found to be hypertensive had never had drug therapy (14.6% against 10.7% in the CHEC series). Of the initial group with positive readings 1,153 were presently on medication and apparently uncontrolled (53% against 16.7% in the CHEC series).

Our findings showed considerably more hypertensive individuals than the CHEC Program (conducted from 1972 to 1975).[10] This is at least partially due to the use of different cut-off values particularly in the systolic blood pressure and to the fact that this figure represents only the initial blood pressure reading. On re-check almost half of the initial elevations became normal.[11] Further, our study found no significant correlation between type of activity and level of blood pressure; the sedentary individuals showed no more or less than active individuals or those in "pressure" jobs. Ninety percent of the people who were screened indicated they were right-handed; and of this number, nine out of ten had the higher reading in the dominant arm. This was not so in the left-handed individuals who had as many higher readings on the right arm as on the left.

ACKNOWLEDGMENT: The authors gratefully acknowledge the help of the screening team—Eileen Capista, Mary Langenhahn, and Alicia Buehler—and thanks to the members of the computer staff at Employers Insurance for their invaluable support and encouragement.

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Abstracts

En bloc removal of large bilateral olfactory groove meningioma

BAHIJ S SALIBI, MD; WILLIAM O MYERS, MD; and JOHN W GILDERSLEEVE, MD, Marshfield Clinic and Marshfield Medical Foundation, Marshfield, Wis: *Surg Neurol* 9:264-266 (Apr) 1978

WITH CAREFUL PREOPERATIVE angiographic evaluation, reversible intraoperative external carotid occlusion, controlled hypotension, steroids, osmotic diuretics, and early control of nutrient arteries, the en bloc removal of a large bilateral olfactory groove meningioma is feasible in some instances. Dissection around the tumor is facilitated by shrinkage of the tumor, as its nutrient vessels are occluded. Ligation and division of the venous drainage is left until the end. This technique may be particularly valuable in poor risk patients, as it may considerably reduce blood loss and operating time, without sacrifice of brain tissue. ■

Refer to: Babbitt DP, Sty JR, Kohler EE: A complication of juvenile rheumatoid arthritis—spontaneous biceps tendon rupture. *Wisconsin Med J* 78:32-33 (Mar) 1979

Key words: Bone (arthritis, joints, complications)

A complication of juvenile rheumatoid arthritis—Spontaneous biceps tendon rupture

Donald P Babbitt, MD; John R Sty, MD and **Elaine E Kohler, MD,** Milwaukee, Wisconsin

• This is a report of a case of spontaneous rupture of the insertion of the biceps tendon in a child with rheumatoid arthritis. Distal biceps tendon rupture is uncommon in pediatrics and to our knowledge has not been reported as a complication of juvenile rheumatoid arthritis.

BEGINNING WITH STILL'S classic treatise on arthritis over 80 years ago, many additional clinical and radiologic descriptions of arthritis have been written.[1,2,3,4] Complications associated with juvenile rheumatoid arthritis include iridocyclitis, amyloidosis, pathologic fractures, carditis, dissecting popliteal cysts, and growth disturbances.[5,6,7] The following report describes a case of spontaneous rupture of the biceps tendon near its insertion.

Case report. A 6-year-old boy presented at the age of 4 years with a rash, fever, pericarditis, and joint pain associated with effusion. At this time the diagnosis of juvenile rheumatoid arthritis was established. Two years later he was hospitalized for an exacerbation of arthritis and pericarditis. While in the hospital, he developed a painful cystic mass on the flexor aspect of the distal humerus. Orthopedic evaluation demonstrated complete absence of the normally palpable flattened tendon of insertion at the radial tuberosity. The proximally retracted muscle mass was noted both clinically and radiographically (Fig 1A, 1B). Operative repair was advised. However, the patient declined treatment and was lost to followup after moving out of state.

Discussion. Spontaneous rupture of a tendon is not reported in children in the absence of trauma. In adults Achilles tendon rupture has occurred in otherwise healthy individuals, but the etiology has been attributed to decreased vascularity.[8,9]

From the Departments of Radiology (DPB, JRS) and Pediatrics (EEK), Milwaukee Children's Hospital, Milwaukee. Reprint requests to: Donald P Babbitt, MD, Dept of Radiology, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201. Copyright 1979 by the State Medical Society of Wisconsin.

In rheumatoid arthritis collagenolysis of the tendon occurs because of abnormal production of proteolytic enzymes such as lysozymes, proteases, and cathepsins.[10,11] In addition, 30% to 40% of patients will demonstrate a moderate inflammatory reaction in the tendon sheaths. In view of

FIGURE 1A—Right arm. Arrows mark the soft tissue mass of the biceps muscle secondary to tendon rupture at the distal insertion.

FIGURE 1B—Left arm. Normal.

these pathologic observations, it is interesting that tendon rupture is not observed more frequently in children.

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Perinatology

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Professor, Department of Obstetrics and Gynecology
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Hyperthyroidism and pregnancy

EDITORIAL NOTE: Better understanding of basic thyroid physiology during pregnancy has brought about a more rational approach to the treatment of hyperthyroidism during pregnancy. The accompanying article outlines a therapeutic approach which has led to consistently successful outcomes in pregnant patients suffering from hyperthyroidism.

SIGNIFICANT ADVANCES in understanding the maternal and fetal pituitary thyroid axis in relation to placental transport have led to a rational approach to the management of hyperthyroidism during pregnancy.

It appears that the maternal and fetal pituitary thyroid feedback function independent of each other as a result of placental impermeability to thyroid-stimulating hormone (TSH), T4, and T3. As a result, excessive production of T3 and T4 by the maternal thyroid gland will have no effect on the fetal thyroid, nor on its target organs. On the other hand, the antithyroid drugs commonly used in the treatment of hyperthyroidism (methimazole and prophylthiouracil) cross the placenta quite freely and, therefore, can cause profound metabolic changes in the fetus when given to the mother.

As a result of reports in the literature describing evidence of fetal goiters and neonatal hypothyroidism in infants born to mothers treated with antithyroid drugs during pregnancy, the surgical treatment of hyperthyroidism was advocated by many. However, more recent reports demonstrate no advantage of surgical over medical treatment, and as a result, careful administration of antithyroid drugs has become the preferable approach.

At the University of Wisconsin Perinatal Center at Madison General Hospital, we have treated 11 patients with either methimazole (Tapazole®) or prophylthiouracil during the past three years. We had one infant with mild transient neonatal hypothyroidism who did well and three premature deliveries secondary to premature rupture of the membranes. These three infants also did well. There were no perinatal deaths.

As a result of our experience and a review of the literature, we have adopted the following guidelines for the management of hyperthyroidism during pregnancy:

1. Prophylthiouracil (PTU) should be the drug of choice. It blocks the glandular synthesis of T4 and also inhibits the peripheral conversion of T4 to T3 and, thus, biologically, it should be more effective in controlling symptoms.

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2. Concomitant thyroid hormones should not be employed. The use of thyroid supplement has not been shown to produce better results, while on the other hand, such treatment carries with it the hazard of neonatal hypothyroidism.
3. Patients should be followed with free thyroxine index determinations (FTI or T_7) every two weeks. Determination of T_3 by radioimmunoassay and thyroid-stimulating hormone (TSH) also are desirable. PTU dose should be adjusted to maintain an upper normal value of FTI.
4. Antithyroid medication requirements will decrease during the second half of pregnancy and, therefore, the dose should be gradually reduced in advance before the FTI becomes too low. Do not wait for a subnormal FTI.
5. Propranolol may be used for rapid control of symptoms until long-term control with PTU is achieved.
6. Because of the high incidence of toxemia, patients must be followed closely, and appropriate therapy should be instituted at the first sign of toxemia.
7. If the patient requires more than 400 mg of PTU daily for proper control, surgical treatment should be considered.
8. Neonates should be carefully observed for hyper- and hypothyroidism. Neonatal hyperthyroidism is transient and appears to be due to transplacental passage of either long-acting thyroid stimulators (LATS), or as has been recently believed, thyroid immunoglobulins. It is of interest that neonatal hyperthyroidism may be seen in infants born of euthyroid mothers who had hyperthyroidism treated before pregnancy.
9. Radioactive iodine is a dangerous drug to give during pregnancy as the fetal thyroid gland starts concentrating I_2 as early as 12 weeks. This treatment should be used only in patients on whom pregnancy has been excluded and who are willing to effectively use contraception.

As with most medical complications of pregnancy, patients with hyperthyroidism present difficult problems to deal with and require the close supervision of the obstetrician, endocrinologist, neonatologist, and other members of the health team. ■

Abstracts

Gastric ulceration in patients receiving intrahepatic infusion of 5-fluorouracil

Thomas Narsete, MD; Fred Ansfield, MD; George Wirtanen, MD; Guillermo Ramirez, MD; William Wolberg, MD; and Fredric Jarrett, MD, University of Wisconsin Hospitals, Madison, Wis: *Ann Surg* 186: 734-736 (Dec) 1977

Intrahepatic infusion of 5-FU via a percutaneously placed arterial catheter has provided successful palliation of tumors metastatic to the liver. Catheter placement was checked every 4-5 days, and catheters were repositioned if necessary. Gastric ulceration occurred in eight patients receiving this therapy, and was complicated by perforation and death in one instance, and bleeding in four. In all eight patients, the infusion catheter tip had been displaced proximal to the stomach's blood supply: three were in the left gastric artery, three in the common hepatic, and two in the celiac axis just proximal to the origin of the left gastric.

A retrospective review was then undertaken of all 251 patients who had received intra-arterial chemotherapy over a two-year period. Catheter displacement occurred in 20 patients (8%), most commonly into the left gastric and gastroduodenal arteries. Five of these patients developed a gastric ulcer and three other patients developed upper gastrointestinal bleeding of undetermined etiology. Almost all of the 20 patients were symptomatic prior to catheter placement check.

The causal relationship between gastric ulceration and intrahepatic infusion is thus suggested by several observations. All eight patients had their catheter tips positioned in a vessel that directly infused the stomach with 5-FU. The incidence of gastric ulceration in this group (8%) is far in excess of that in the normal population (0.1-0.4%) and occurred with a reversed male/female ratio. No duodenal ulcers were noted.

Prompt determination of catheter placement is necessary in patients receiving intrahepatic arterial infusion of 5-FU for cancer metastases to the liver. An aggressive approach for gastric ulcers is indicated due to their high complication rate in this group of patients. ■

Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Through the microscope — To determine prognosis and improve treatment of childhood cancers

THE MICROSCOPE HAS always been an essential tool for diagnosing leukemia in children by identifying the presence of lymphoblasts in the peripheral blood smear; determining the presence of thrombocytopenia, anemia, and leukocytosis; and demonstrating the replacement of normal bone marrow by lymphoblasts. It is also needed to determine the cause of swollen glands, the type of brain tumor, or the extent of bone involvement in osteosarcomas.

During the past 15 to 20 years, some of the most notable successes in cancer treatment have occurred in the treatment of childhood cancer. The death rate has decreased from 8.4 per 100,000 in 1950 to 5.3 per 100,000 in 1974. A great deal of this improvement has been due to the efforts of cooperative groups which have studied enough patients so that successes and weaknesses of the treatment methods could be determined.

Many people still believe that cancer is one disease, but physicians now recognize several hundred different types. In many ways the more knowledge we accumulate, the more complex the classification of neoplasms becomes. For example, we now know that a disease like acute lymphocytic leukemia is not a homogeneous disease; subsets are beginning to be identified which require different treatments.

According to Dr N Shahidi, director of Pediatric Hematology-Oncology of the University of Wisconsin Center for Health Sciences in Madison, children who have an initial white blood cell count (WBC) of less than 10,000 per cu mm and who are between three and seven years of age belong to a group who have a very favorable prognosis. This group accounts for about a third of all children with acute lymphocytic leukemia (ALL) and over 85% of them will be alive four years after the start of treatment. A subset consisting of over half of the ALL patients will be less than three or older than seven but have a low WBC; almost 70% of this group will still be alive four years later. Of those children with a WBC above 50,000 per cu mm (a fifth of the patients), only about 40% will survive for four years.

Other factors which appear to influence a favorable outcome are absence of a mediastinal mass or enlargement of the liver, spleen, or lymph nodes. Patients with Down's syndrome have a lower complete remission rate, while a patient who is female, white, and has a complete response to therapy in less than thirty days has a better survival. Children with anemia have a better prognosis. A high level of serum immunoglobulins, especially IgG, although not an independent prognostic factor, adds weight to age and WBC. They are related to remission duration and relapse rates, with relapse rates higher in those patients with depressed levels of IgG, IgA, and IgM.

But microscopic studies can tell even more. Much of the success of chemotherapy seems to be related to the rate at which cell numbers are reduced. This is best determined by studying smears of the leukemic blood and checking the bone marrow cellularity at specified intervals after the start of therapy.

A study of the lymphoblast morphology shows that the small L_1 blasts are associated with a lower rate of bone marrow relapse. These studies also identify a subset of patients who have a higher early relapse rate.

T cell lymphocytes are a poor prognostic factor, while null cell markers are favorable. Likewise large macroblasts indicate a poor prognosis.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

PAS (periodic acid Schiff) histochemistry of less than 40% is associated with a lower complete remission rate. And of course, patients with central nervous system disease have a lower complete remission rate.

Studies with acute myelogenous leukemia have shown that relapse occurs when there has not been sufficient reduction of cell numbers, when resistance to the chemotherapeutic drugs develops, when pharmacologic sanctuaries develop, and when the pluri-potential stem cell pool is premalignant.

Many of the laboratory microscopic tests which must be done to successfully diagnose and treat these pediatric neoplasms require great skill and must be done on properly prepared tissue and blood samples at specific times before and during treatment. Dr Jonathan Finlay, who performs the leukemia cell surface marker studies at the University of Wisconsin Center for Health Sciences, stresses the importance of checking on proper sample preparation before doing biopsies, bone marrow studies, spinal taps, or giving cytotoxic drugs to children suspected of having leukemia, lymphomas, Hodgkin's disease, or solid tumors. Doctor Finlay may be contacted for further information regarding the recommended methods of preparation.

Dr Emil Frei III, during his recent visit to the University of Wisconsin as the Karl Beyer Visiting Professor, stressed that "the progress being made with leukemia continues to serve as a prototype for other types of neoplasia."

By following the microscopic characteristics of these childhood neoplasms and the changes which occur during chemo- and radiotherapy, the treatment of all subsets of these diseases and other types of neoplasms will hopefully be improved and the morbidity and long-term complications reduced.

—Dorothy J Buchanan-Davidson, PhD
Science Writer ■

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TENTATIVE SCHEDULE

Orthopedic Field Clinics

January 1979 through June 1979

STATE DEPARTMENT OF PUBLIC INSTRUCTION, DIVISION FOR HANDICAPPED CHILDREN

Bureau for Crippled Children

Location	*Date*	*Examiner*
Chippewa Falls	Mar 22	C Davis, MD
Ashland	Mar 29	WT Brodhead, MD
Lancaster	May 2	JD Heiden, MD
	May 3	JE Huffer, MD
Rhinelander	May 9	HI Okagaki, MD
Darlington	May 23	GH Vogt, MD

Through orthopedic field clinics, the Bureau for Crippled Children (BCC) provides diagnostic examinations and consultation for persons under 21 years of age, primarily in areas where orthopedic consultation is not readily available.

Referrals may be made to BCC by family physicians, nurses and therapists who may attend the clinic if they desire, and will receive reports following clinics.

REFERRAL FORMS: Should be obtained from BCC (see below) and returned to us *well in advance* of the clinic date. We need to know the number of children to be seen at clinic so that we may schedule appointments and notify parents and others of the clinic appointment time and date and invite them to attend.

Children should be screened carefully to determine the need for an orthopedic examination and that they are not already under the care of an orthopedist.

Please complete *all* information on the referral form. Under "Reason for Referral" describe the *specific* condition. In the blank space in the upper left hand corner, please indicate the name and address of the referring agency or person.

ADDRESS CORRESPONDENCE TO: BUREAU FOR CRIPPLED CHILDREN, 126 Langdon St, Madison, WI 53702. Tel: 608/266-3726

REQUEST _____ clinic referral forms
number

for _____ orthopedic clinic on

_____. NAME AND ADDRESS
date

OF REFERRING AGENCY _____.

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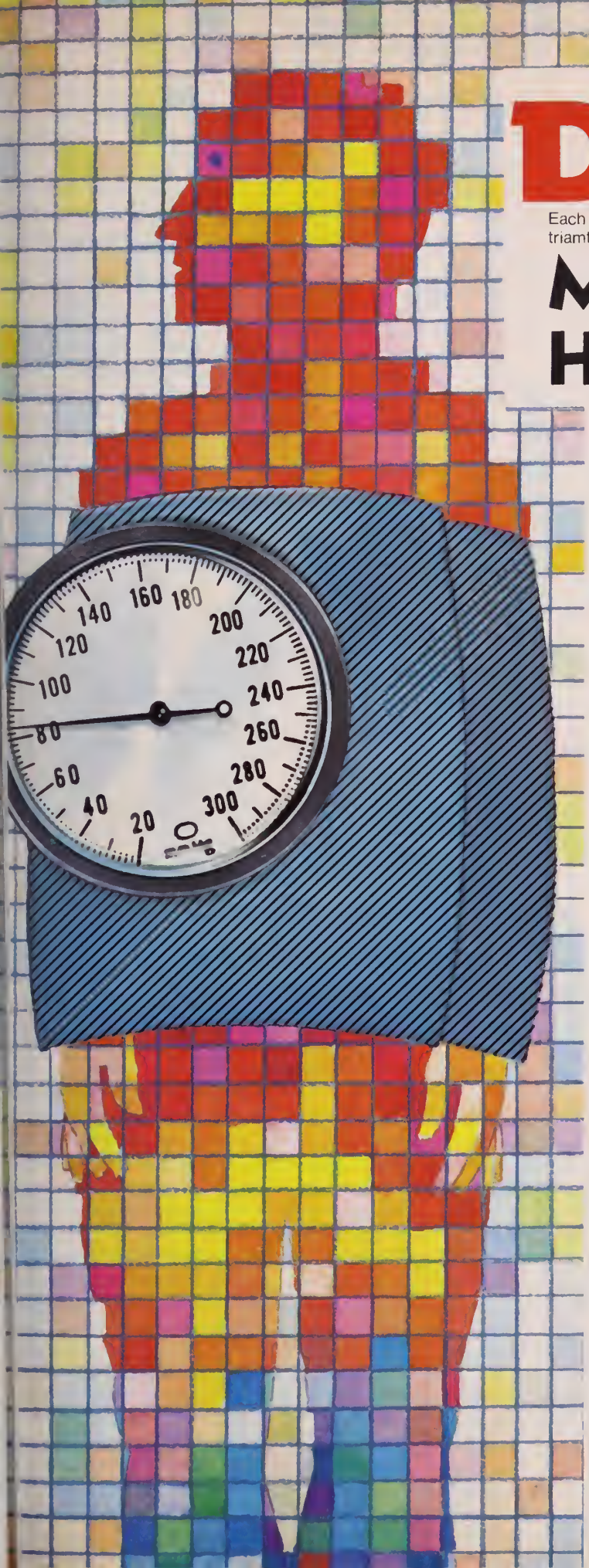

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Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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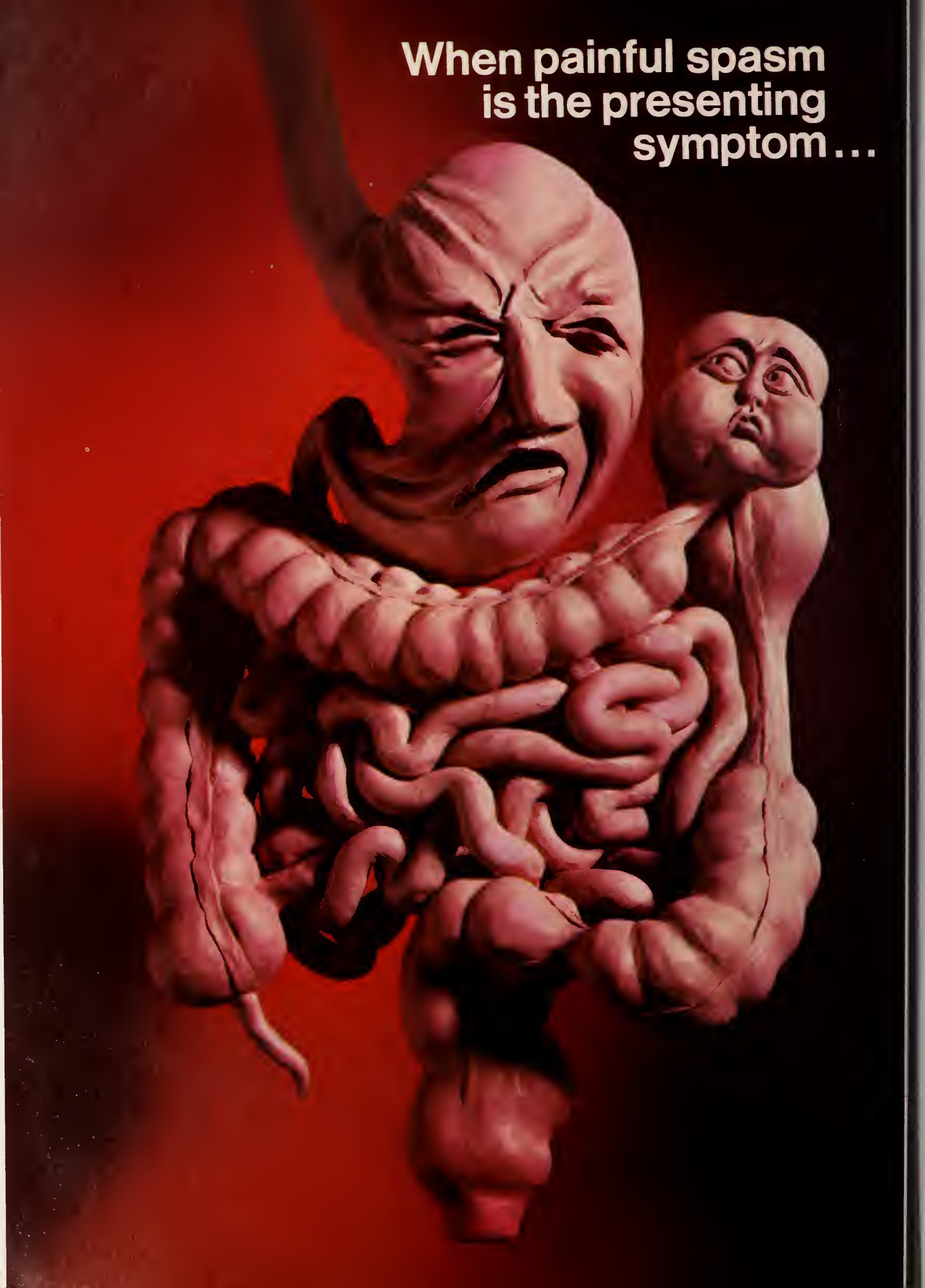
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In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.

Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective.

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste, headache; nervousness; drowsiness; weakness; dizziness; insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*: 1 capsule or teaspoonful syrup three or four times daily. *Infants*: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*: 1 tablet three or four times daily. Bentyl Injection: *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. It indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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Organizational SMS

Council proposes to modify unified membership rule

The SMS Council February 3 voted to place the issue of unified membership in Wisconsin squarely before the SMS House of Delegates. At the H/D Annual Session in May, the Council will introduce an amendment to the SMS Constitution to remove the mandatory AMA membership rule. Presently in Wisconsin, a physician wishing to be a member of organized medicine must join the state, county, and national medical organizations.

A recent poll the State Medical Society conducted of all Wisconsin physicians showed that 56% of the responding member physicians and 92% of the responding nonmembers *opposed* the unified membership requirement in Wisconsin. More than 57% of the approximately 4,500 member physicians in Wisconsin and 29% of the 2,696 nonmembers responded to the survey.

According to the SMS Constitution, a proposed amendment cannot be acted upon by the House until one year after its introduction. A proposed amendment presented in 1979 would then be acted upon at the 1980 Annual Session and become effective January 1, 1981.

The Council urges county medical societies to review carefully the results of the unified membership poll in order to sufficiently advise local delegates to the SMS Annual Session.

Other Council action

Meeting in Madison February 3, the Council:

- Approved a budget of $1,297,700 for 1979. Projected income for 1979 is $1,330,000.
- Adopted a series of recommendations to coordinate public-private peer review in Wisconsin. These recommendations are: 1) a joint Board of Directors for public-private peer review should be formed, comprised of six members of WISPRO and the present Board of Directors of Wisconsin Review Foundation (WRF); 2) one chief executive officer, namely Earl R Thayer, should direct the functions of the joint WRF/WISPRO organizations; 3) support and cooperation will be given to staff selected by the chief executive officer, and 4) the operating committees of both WRF and WISPRO should be consolidated promptly. The Boards of WRF and WISPRO also have approved these recommendations.
- Approved a Title 19 provider agreement to be issued by the State Department of Health and Social Services in conjunction with the Super-Rule. This two-paragraph document will replace the interim T-19 contract.
- Appointed William L Treacy, MD, Milwaukee, to the Physicians Alliance Commission and Harlan M Levin, MD, Janesville, to the *Wisconsin Medical Journal* Editorial Board to fill the unexpired terms, respectively, of Paul Jacobs, MD, Milwaukee, and Garrett A Cooper, MD, Madison. Doctor Cooper was made an emeritus member of the Board.
- Formally expressed its gratitude to Mr Howard O Brower for his 14 years of service as an employee of the Society. ■

Alliance, Council approve new provider agreement

Meeting in Madison, February 2, the Physicians Alliance Commission reviewed and approved the wording of the new provider agreement which will be issued by the Wisconsin Department of Health and Social Services in conjunction with the Medical Assistance "Super-Rule." The two-paragraph document will replace the three-page interim T-19 contract.

The SMS Council subsequently approved the new agreement at its meeting February 3.

Last fall the Commission and the Council directed the Alliance Staff to seek changes in the current interim provider contract and the work for the development of an agreement which only reflects the minimum requirements for contracts as suggested by the federal Social Security Act and subsequent enabling legislation. Further information appears in the IN PERSPECTIVE column of this issue and in the T-19 UPDATE columns of *Medigram.* ■

Health planning conference set for June 8-9 in Madison

The SMS Health Planning Commission has announced sponsorship of a major health planning conference in Madison, June 8-9, at the Concourse Hotel.

The conference is designed to give participants an overview of health planning laws, what the State Medical Society is doing to involve physicians in health planning through the Wisconsin Physicians Planning Network (WPPN), as well as an academic view of the need for health planning. Speakers will include individuals from state and federal government, physicians actively involved in health planning, and local health planners. While the conference is aimed primarily at Wisconsin physicians, other interested persons are welcome to attend. For more information contact the Health Services Division of the State Medical Society: 257-6781 (in Madison area) or toll-free 1-800-362-9080. Further details also appear in the YELLOW PAGES section of this issue. ■

Governmental Affairs takes no stand on drinking legislation

Saying that it would have little effect on reducing teenage drinking problems or availability of liquor to teenagers, the SMS Governmental Affairs Commission February 14 took no position on a number of bills proposing to raise the legal drinking age in Wisconsin.

So far this legislative session, three bills have been introduced which would raise the drinking age to 19. Two other bills would raise the age at which an individual could buy "carryout" liquor and would not raise the drinking age in licensed establishments.

In choosing not to take a formal stance at this time on any of the bills, Commission members felt that raising the drinking age would not significantly reduce the teenage drinking problem in Wisconsin and instead may delay more effective actions such as changing adult attitudes, increasing local community action programs, developing advertising guidelines, and stricter law enforcement.

The Society's Commission on Alcohol and Other Drug Abuse will study these proposals in-depth at its March 28 meeting and report its recommendations to the Commission on Governmental Affairs.

At its February 14 meeting the Commission also:

- Asked James Torhorst, MD, Madison, to set up a committee of OB/GYN Section members to study and make recommendations on AB 66, the midwifery bill. AB 66 proposes to establish a nurse midwifery licensing program in Wisconsin.
- Endorsed SB 2 and 3 which would give the State Legislature watchdog powers over state agencies when they promulgate administrative rules.
- Endorsed legislation being proposed by the Occupational Therapists Association that would certify occupational therapists in Wisconsin through the State Medical Examining Board. ■

New specialty services program underway at SMS

The State Medical Society recently announced a new program offering administrative executive services to specialty societies and allied health groups. While the Society has provided services of this nature on a limited basis in the past, the new specialty services program expands the scope of these services and makes them more readily available at minimal cost.

Services offered under the program include such executive services as: legislative and administrative representation, health planning analysis, convention and meeting management, and staff assistance.

Among the administrative services available are: maintenance of membership rosters and records, membership solicitation, layout and printing services for newsletters, etc, maintenance of financial records and general clerical assistance.

A fundamental objective of this specialty services program is to help unify the many components of medical practice in Wisconsin, while at the same time aid the membership of the individual specialty associations. If specialty societies would like more information regarding this program and its services, they should contact Bill Wendle at the SMS Health Services Division in Madison. ■

SMS annuity unit value: $2.52

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians, was $2.52 as of January 31, 1979. ■

Council meeting date changed

The March 10 meeting date of the SMS Council was cancelled and the new date of April 7 was scheduled at the SMS headquarters building in Madison. ■

UW Clinical Science Center dedicated. The University of Wisconsin-Madison formally dedicated its new Clinical Science Center February 23 marking completion of the largest building project in Wisconsin state history. Taking part in the ceremonies were Wisconsin Governor Lee Dreyfus and former Governor Warren Knowles. The new building will house the University Hospitals and Clinics, the School of Nursing, Medical School clinical activities, and the Wisconsin Clinical Cancer Center. On March 31 some 300 patients will move from the old University Hospitals located two miles east of the new structure. The State Medical Society and the UW Medical School ended the week-long dedication events with a Leadership Conference at the new facility for state physicians and medical alumni. During the morning part of the program, the approximately 200 physicians in attendance were updated on recent activities at the State Medical Society in such areas as state legislation, communications, peer review, health planning, and SMS strategies for 79-80. The afternoon session provided an academic view of health planning. ■

FAS pamphlet now available in Spanish version. A Spanish version of the pamphlet "Alcohol and Your Unborn Baby" is available on request to physicians, organizations, and groups which serve Spanish-speaking Americans. The "mini" pamphlet alerts women to the potentially harmful effects alcohol can have on their unborn children. To order copies contact the SMS Communications Dept in Madison. ■

Members, Committee on Nominations

James J Tydrich, MD, Richland Center
Chairman

Chesley P Erwin, MD, Milwaukee
Secretary

District

1 John D Riesch, MD, Menomonee Falls
Chesley P Erwin, MD, Milwaukee
Jerome J Veranth, MD, Racine
David N Goldstein, MD, Kenosha

2 John K Scott, MD, Madison
(appointed as substitute for James N Moore, MD)
James J Tydrich, MD, Richland Center

3 Vernon M Griffin, MD, Mauston

4 Richard H Ulmer, MD, Marshfield

5 Timothy T Flaherty, MD, Neenah
(appointed as substitute for Kenneth M Viste, MD)

6 Gilbert H Stannard, MD, Manitowoc

7 John A May, MD, Baldwin

8 Joseph M Jauquet, MD, Ashland

Specialty Sections
Joel E Taxman, MD, Milwaukee

NOMINEES . . .

1962-1965. Certified by American Board of Radiology in 1966. Practicing general radiology in Oshkosh, Neenah, and Menasha since 1965. On medical staff of Mercy Medical Center and Theda Clark Regional Medical Center. Member of SMS House of Delegates, 1966-1972, and member of SMS Council 1972-1977. Chief-of-staff at Mercy Medical Center, Oshkosh, 1973-1974. Alternate delegate to American College of Radiology, 1971-1973. Currently is SMS alternate delegate to American Medical Association, 1979. Member of Winnebago County Medical Society, American College of Radiology, Radiology Society of North America, Board of Directors of YMCA, Oshkosh, and Board of Directors of Lourdes Academy, Oshkosh. ■

Watch April issue for details of

1979 Annual Meeting

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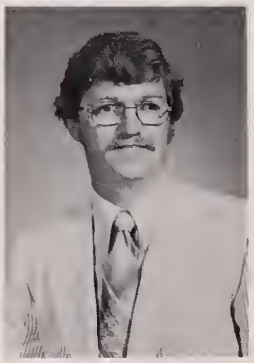

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Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.
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Annual Meeting: 24 resolutions set issues

The House of Delegates will consider resolutions ranging in subject matter from unified membership to the health effects of energy generating sources at the State Medical Society's Annual Meeting in Milwaukee, May 10-12.

The following resolutions were received in the Secretary's office by the March 9 deadline. These will go to the House of Delegates for action during its three sessions at the MECCA in Milwaukee. Members are urged to express their opinions to their delegates (see page 52 for list) and to participate at the Annual Meeting Reference Committee hearings where resolutions are discussed.

Highlights of the Annual Meeting Program will appear in the April issue.

(The county medical society, individual physician, or specialty section which introduced the resolution appears in parentheses.)

1. (Council) Unified Membership

"RESOLVED, that the Council of the State Medical Society of Wisconsin introduce to the 1979 House of Delegates a recommended amendment of the Constitution, pursuant to Article XIII thereof, to delete from Article IV wording which mandates membership in the American Medical Association, such Article then to read as follows:

"This Society shall consist of members who shall be the members of the component county medical societies, ~~and who shall also be members in good standing of the American Medical Association, and~~ who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary."

2. (Council) Support of American Medical Association

"RESOLVED, that every member of the State Medical Society of Wisconsin be encouraged and advised to support the American Medical Association by membership and by continuing constructive participation in its affairs; and be it further

"RESOLVED, that the American Medical Association be encouraged to undertake continuing strenuous efforts to inform the physicians of Wisconsin of the benefits of membership in the American Medical Association and solicit such membership."

3. (District I Delegation) Unified Membership

"RESOLVED, that the State Medical Society of Wisconsin House of Delegates once again adopts and continues the policy of unified membership in the State of Wisconsin, and be it further

"RESOLVED, that the leadership of the State Medical Society of Wisconsin and component societies support and promote unified membership."

4. (Board of Directors, Medical Society of Milwaukee County) Unified Membership

"RESOLVED, that the House of Delegates is urged to adopt an amendment (by deletion of certain wording) in Article IV of the SMS Constitution as follows:

" 'This Society shall consist of members (who shall be members of the component medical societies, and who shall also be members in good standing of the American Medical Association, and) who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the Society.'

"RESOLVED, that adoption of this amendment by the House will manifest that individual members still have a voice in determining the policies of their State Medical Society, and that their elected representatives in the House are responsive to the will of the majority."

5. (Wood) Unified Membership

"RESOLVED, that membership in the American Medical Association no longer be a requirement for membership in the State Medical Society of Wisconsin."

6. (LaCrosse) Unified Membership

"RESOLVED, that in support of the State Medical Society majority, the LaCrosse County Medical Society endorses the proposal to abolish unified membership."

7. (LaCrosse) Membership Referenda

"RESOLVED, that the House of Delegates direct the Council to review with appropriate legal consultation Article XI of the Constitution and recommend changes if needed to be certain that it does truly afford a mechanism for referendum on an issue before the House of Delegates."

8. (District I Delegation) Polls, Surveys and Referendums

"RESOLVED, that opinion polls and surveys may be used to determine the sentiment and define problems among the membership; and be it further

"RESOLVED, that any opinion gathering process employing the mail and intended to decide major issues be clearly labeled as a referendum and the membership appraised of its intended use; and be it further

"RESOLVED, that provisions be made for the supporters of each side of a major issue to be heard; and be it further

"RESOLVED, that a referendum shall deal with a solitary question; and be it further

"RESOLVED, that a method be developed for counting the results of a referendum, as a guideline to State and component societies."

9. (EJ Nordby, MD, Treasurer) Office of Treasurer

"RESOLVED, that holding of the office of Councilor and Treasurer be allowed as an exception to Article IX, Section 1, of the Constitution; and be it further

"RESOLVED, that the Chairman of the Finance Committee of the Council be elected as Treasurer of the Society each year; and be it further

"RESOLVED, that such Assistant Treasurers as necessary may be elected for the convenience of signing checks."

10. (Resident Physician Section) Medical Student Loan Repayment

"RESOLVED, that the State Medical Society of Wisconsin study the problem of medical student indebtedness; and be it further

"RESOLVED, that the Council of the State Medical Society take whatever steps are appropriate and feasible to help arrange for repayment deferral of medical student educational loans until after postgraduate training."

11. (District I Delegation) Physician Dues Reduction

"RESOLVED, that the State Medical Society of Wisconsin study this problem (limited incomes) in the hope that physicians who so state their limited income might be allowed to enjoy reduced dues for membership in the State Medical Society."

12. (Section on Internal Medicine for the Wisconsin Society of Internal Medicine) Equitable Risk Classifications in Medical Liability Premiums

"RESOLVED, that the State Medical Society of Wisconsin supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category."

13. (District I Delegation) Preferential Hospital Rates

"RESOLVED, that the State Medical Society of Wisconsin oppose hospital charge arrangements granting unwarranted advantage to any group of patients; and be it further

"RESOLVED, that the State Medical Society of Wisconsin adopt a policy urging all health care payors, government and private, to pay their equitable share of costs incurred by hospitals and other facilities; and be it further

"RESOLVED, that the State Medical Society of Wisconsin initiate discussions with representatives of the Wisconsin Hospital Association, exploring the subject of preferential hospital rates and recommending remedial and preventative measures."

14. (District I Delegation) Health Care Insurance and AMA Policy

The following resolution, pertaining to a national health insurance bill, was passed by the AMA House of Delegates at its Interim Session in December 1978:

"Resolved, that the American Medical Association recommend to the Congress of the United States of America modifications to our present health care system embodying the following principles:

"1. Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and co-insurance.

"2. A simple system of uniform benefits provided by the Federal, State and local governments for those individuals who are unfortunate enough (through no fault of their own, *ie,* age, disability, financial hardship, etc) not to be able to provide for their own medical care.

"3. A nationwide program by the private insurance industry of America (and government if necessary for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and co-insurance to make it economically feasible and to avoid abuse.

"4. A program developed pursuant to these principles should be administered at the State level with national standardization through Federal guidelines."

"RESOLVED, that the State Medical Society of Wisconsin House of Delegates endorse the actions of the AMA House of Delegates with the exception of the reference in #4, "with national standardization through Federal guidelines;" and be it further

"RESOLVED, that the AMA Board of Trustees be informed of this endorsement by written communication from the Speaker of the House."

15. (District I Delegation) Second Opinions

The following American Medical Association policy statement was adopted at the Interim Meeting of the House of Delegates in December 1978:

"Recognizing that the advisability of surgery or other specific therapy can be a matter of opinion, the House of Delegates of the American Medical Association (1) affirms the right of a patient or a physician to seek second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third party payor for not obtaining a second opinion; (3) supports the concept that, when a second opinion is required by a third party, that second opinion should be at no cost to the patient."

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin endorse the American Medical Association statement and accept it as SMS policy."

16. (Dane) Physicians Alliance Division

"RESOLVED, that the Speaker of the SMS House of Delegates appoint a committee to review activities of the Physicians Alliance Division, and to advise the SMS members of its findings related to: (1) Meeting the House of Delegates and Physicians Alliance goals, (2) Expenditures relating to specific activities and wages within its budget, and to (3) Recommend any changes needed to continue the Physicians Alliance as an effective tool with full support of the membership."

17. (Environmental Health Committee of the Commission on Governmental Affairs) Clean Energy

"RESOLVED, that the AMA House of Delegates re-evaluate its support for the Council on Scientific Affairs report, 'Health Effects of Energy Generating Sources'; and that the AMA House of Delegates commission an independent study to review current and projected health effects of energy generating sources: and be it further,

"RESOLVED, that the AMA House of Delegates support efforts to improve coal mining safety and eliminate disease and disability; and that the AMA support the application of scrubbers and maximum use of reasonably available technology to coal burning plants to reduce emissions of sulfur dioxide and other air pollutants; and that the AMA call upon Congress to deal effectively with the unresolved problems of the uranium mine tailings; and that the AMA urge the federal government to move quickly to develop a safe method of disposition of spent fuel rods from nuclear power plants; and that the AMA support efforts to encourage more efficient use of the energy we are currently generating; and that the AMA encourage government bodies to increase their support of clean and renewable energy sources, such as solar, by increased funding for research and greater tax incentives."

18. (District I Delegation) Restoration of the Drinking Age to 21 Years

"RESOLVED, that the State Medical Society of Wisconsin support restoration of the legal drinking age to 21 years."

19. (District I Delegation) Brain Death

"RESOLVED, that the Wisconsin Legislature be stimulated toward leaving the definition of brain death to a duly constituted panel of experts working in continuum in the area."

20. (District I Delegation) Council of Information and Communications

"RESOLVED, that a Council of Information and Communications be established by the State Medical Society. This Council would have no formal meetings but should function as a communications organization. (This Council should consist of one representative from each hospital staff over 30 bed capacity. This representative is to receive direct communication from the central office on a weekly basis and will be in charge of disseminating this information to the hospital staff and returning comments and suggestions to the central office — word of mouth or a Medical Society bulletin board may be utilized with a suggestion box.) Although this Council will have no formal meetings scheduled, its function is paramount to our present environment."

21. (Wood) Horvath Occupational Health Resolution

Small-to-medium sized industries, which employ the majority of Wisconsin workers, frequently cannot afford to retain the services of full time occupational health personnel; and The Wisconsin Division of Health — Section of Occupational Health has been providing much-needed industrial hygiene and occupational nursing consultive services to the State's employers, free of charge; and industrial hygiene and occupational health nursing are indispensable to the success of any occupational health program; and the 1979-81 biennial budget for the Division of Health plans to cut 15 occupational health staff positions; therefore be it

"RESOLVED, that the State Medical Society shall oppose the reduction of occupational health staff in the Division of Helath."

22. (Section on Ophthalmology) Allied Health Care Practitioners

"RESOLVED, that the State Medical Society support legislation or administrative rule action which would develop mandatory referral criteria and/or guidelines for these allied health care practitioners in order to promote prompt and effective health care treatment for the citizenry and to protect patients from inadequate care.

23. (District I Delegation) Medical School Loss of Income

The Medical College of Wisconsin and the University of Wisconsin Medical School have geared up their medical school programs because of earlier Federal government mandates; and recent Federal and State officials have now called for a reduction in medical school enrollment; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin contact Wisconsin legislators and Secretary Califano of HEW to protect the medical schools against these losses."

24. (District I Delegation) Medical Ethics

"RESOLVED, that the State Medical Society of Wisconsin launch a program of awareness, calling for continued exercise of the highest ethical behavior; and be it further

"RESOLVED, that the State Medical Society of Wisconsin obtain and disseminate updated information and current guidelines for ethical behavior in intra-professional and physician-patient relationships; and be it further

"RESOLVED, that the State Medical Society of Wisconsin distribute to the membership important papers and guidelines resulting from the current deliberations of the AMA Ad Hoc Committee on the Principles of Medical Ethics; and be it further

"RESOLVED, that the Wisconsin medical schools be encouraged to place new and greater emphasis on personal and professional ethics in the student curriculum."■

State Medical Society of Wisconsin

DELEGATES AND ALTERNATES - 1979

County Medical Society	Delegates	Alternates
FIRST DISTRICT		
KENOSHA	D.N. Goldstein	L.H. Huberty
	C.E. Peterson	S.R. Rosen
MILWAUKEE	D.S. Bruno	Charles Aprahamian
	M.C. Collopy	J.A. Chopyak
	P.A. Dudenhoefer	J.W. Cornell
	C.P. Erwin	T.G. Dehn
	W.E. Finlayson	G.J. Dorff
	G.F. Flynn	D.K. Dunn
	H.R. Foerster, Jr.	C.S.L. Eisenberg
	J.W. Fons, Jr.	K.S. Fabric
	L.B. Glicklich	B.H. Field, Jr.
	Marvin Glicklich	R.J. Goldberger
	S.F. Horwitz	J.J. Goodman
	M.T. Jaekels	S.W. Gorens
	S.A. Korducki	S.A. Graziano
	P.G. LaBissoniere	D.S. Haskell
	R.E. Laubenheimer	J.J. Homsey
	J.D. Levin	J.T. Hotter
	R.F. Madden	J.D. Hurley
	J.A. Means, III	M.R. Jennison
	D.D. Mellencamp	A.E. Kagen
	J.P. Mullooly	B.W. Kennedy
	G.V. Murphy	J.M. Kenney
	A.R. Pequet	L.S. Larson
	R.B. Pittelkow	G.L. Mendeloff
	Shimpei Sakaguchi	D.D. Miller
	K.E. Sauter	W.C. Parks
	D.P. Schlueter	A.L. Pohl
	K.M. Smigielski	L.J. Polacheck
	J.L. Teresi	D.A. Reasa
	W.L. Treacy	T.A. Reminga
	H.F. Twelmeyer	R.J. Scrimenti
	Marvin Wagner	H.F. Weisberg
	R.R. Watson	D.M. Willson
	DeLore Williams	C.E. Young
	R.C. Zastrow	F.L. Ziehl
OZAUKEE	J.E. Kippenhan	A.L. Huckaby
RACINE	E.P. Gander	H.L. Ericson
	M.G. Parker	J.W. Foreman
	R.E. Skupniewicz	W.J. Madden
	J.J. Veranth	C.H. Patton
WALWORTH	I.J. Bruhn	R.S. Galgano
WASHINGTON	C.S. Geiger, Jr.	W.J. Listwan
WAUKESHA	K.J. Dempsey	R.J. Darling
	T.A. Hofbauer	W.B. Davies
	W.H. Konetzki	J.C. Hanson
	G.D. Miller	C.E. Holmburg
	J.D. Riesch	M.J. Popp
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	R.T. Cooney	M.L. Janssen
DANE	M.A. Cunningham	C.L. Andringa
	C.H. Geppert	S.W. Boyer
	J.E. Gutenberger	J.B. Davis
	E.E. Johnson	R.A. Graf
	J.D. Kabler	E.B. Greenberg
	T.C. Meyer	R.J. Hendricks
	J.N. Moore	W.J. Hisgen
	V.W. Nordholm	P.A. Joo
	S.L. Osborne	F.H. Koenecke, Jr.
	J.K. Scott	R.D. Lindgren
	R.W. Shropshire	Sanford Mackman
	P.O. Simenstad	C.H. Mann
	C.A. Taylor, Jr.	P.P. Rank
	C.B. Weston	Phillip Schoenbeck
DODGE	C.W. Bush	R.F. Boock
GRANT	G.C. Hillery	L.E. Becher
GREEN	M.S. Blumenthal	J.E. Erlandson
	Vacancy	Vacancy
IOWA	T.A. Correll	H.P.L. Breier
JEFFERSON	D.E. Bates	R.R. Liebenow
LAFAYETTE	None authorized	None authorized
RICHLAND	J.J. Tydrich	R.W. Edwards
ROCK	Jordan Frank	R.M. Baldwin
	M.F. Purdy	A.L. Reinardy
SAUK	I.A. Galarnyk	J.A. DeGiovanni
THIRD DISTRICT		
CRAWFORD	E.M. Dessloch	Vacancy
JUNEAU	V.M. Griffin	Jack Strong
LA CROSSE	J.T. Murphy	W.C. Boyd
	D.L. Nelson	K.P. Grill
	K.L. Newcomer	J.M. Lockhart
	S.B. Webster	P.S. Shultz
MONROE	R.R. Buan	K.M. Nararimhan
TREMPEALEAU-JACKSON-BUFFALO	J.H. Noble	S.E. Schaefer
VERNON	R.A. Starr	T.E. Boston

County Medical Society	Delegates	Alternates
FOURTH DISTRICT		
CLARK	B.O. Gungor	R.V. Reddy
FOREST	B.S. Rathert	E.F. Castaldo
LANGLADE	J.O. Moermond, Jr.	T.C. Fox
LINCOLN	J.S. Janowiak	G.C. Kloster
MARATHON	G.R. Hammes	W.G. Locher
	J.D. Kramer	T.O. Miller
	J.G. Sack	W.B. Rudy
ONEIDA-VILAS	I.N. Nevin	W.E. Raduege
PORTAGE	P.K. Hacker	B.C. Palaganas
PRICE-TAYLOR	J.R. Keuer	W.W. Meyer
WOOD	R.L. Hansen	W.J. Boulet
	M.P. Mehr	W.J. Maurer
	J.E. Thompson	J.P. Milbauer
	R.H. Ulmer	C.C. Sorensen
FIFTH DISTRICT		
CALUMET	J.W. Knauf	Julio DeArteaga
FOND DU LAC	R.S. Pelton	E.T. Sanfelippo
	K.A. Stormo	D.R. Weber
GREEN LAKE-WAUSHARA	J.C. Koch	A.R. Gimenez
OUTAGAMIE	J.K. Burr	C.F. Dungar
	P.M. Cunningham	J.S. Harris
	J.C. Zeiss	R.R. Kinde
WAUPACA	L.P. Maasch	D.M. Lochner
WINNEBAGO	G.W. Arndt	G.R. Anderson
	J.L. Basiliere	C.C. Baltz
	O.E. Larson	C.R. Lyons
	K.M. Viste, Jr.	J.A. Mathison
SIXTH DISTRICT		
BROWN	G.R. Kaftan	B.C. Bressler
	J.E. Martin	J.A. McIntyre
	C.W. Troup	L.D. Philipp
	R.L. von Heimburg	D.R. Sipes
DOOR-KEWAUNEE	J.J. Beck	D.E. Papendick
MANITOWOC	G.H. Stannard, Jr.	J.D. Lynch
MARINETTE-FLORENCE	C.E. Koepp	J.E. Kraus
OCONTO	J.S. Honish	K.L. Strebe
SHAWANO	W.W. Grover	J.J. Albright
SHEBOYGAN	R.A. Keller	I.L. Schroeder
	J.B. Kuplic	S.C. Westcott
SEVENTH DISTRICT		
BARRON-WASHBURN-BURNETT	D.E. Riemer	J.F. Maser
CHIPPEWA	M.W. Asplund	R.A. Henry
EAU CLAIRE-DUNN-PEPIN	P.J. Happe	S.G. Brown
	K.E. Walter	G.E. Owen
	J.E. Willard	J.B. Young
PIERCE-ST. CROIX	D.M. Woest	J.E. Powell
POLK	M.E. Wegner	J.O. Simenstad
RUSK	J.E. Murphy	R.P. Bennett
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	J.M. Jauquet	A.A. Koeller
DOUGLAS	C.M. Scott	T.J. Doyle
SAWYER	M.H. Sahs	Vacancy
SPECIALTY SECTIONS		
ALLERGY & CLINICAL IMMUNOLOGY	J.J. Ouellette	S.R. Hirsch
ANESTHESIOLOGY	J.T. Small	W.J. Holtey
DERMATOLOGY	J.E. Taxman	H.V. Moss, Jr.
EMERGENCY MEDICINE	W.E. Hein	C.R. Turner
FAMILY PHYSICIANS	R.F. Purtell, Jr.	J.O. Grade
INTERNAL MEDICINE	M.J. Mally	Vacancy
MEDICAL FACULTIES	M.J. Ciccantelli	M.J. Javid
NEUROLOGY	Francis Kruse, Jr.	M.P. McQuillan
NEUROSURGERY	G.A. Meyer	R.L. Suechting
OBSTETRICS-GYNECOLOGY	W.E. Martens	R.P. Reik
OPHTHALMOLOGY	D.K. Ryan	D.J. Kontra
ORTHOPEDICS	P.A. Jacobs	R.P. Johnson
OTOLARYNGOLOGY	T.W. Grossman	D.S. Blatnik
PATHOLOGY	E.A. Burg, Jr.	R.E. Carlovsky
PEDIATRICS	R.L. Myers	W.H. Bartlett
PHYSICAL MEDICINE AND REHABILITATION	W.J. LaJoie	R.M. Krout
PLASTIC SURGERY	H.J. Hoops, Jr.	G.J. Korkos
PSYCHIATRY	C.W. Landis	C.E. Moore
PUBLIC HEALTH AND PREVENTIVE MEDICINE	G.P. Ferrazzano	R.W. Biek
RADIOLOGY	L.E. Hart	B.C. Kirkham
RESIDENTS	D.D. Fuhrmann	T.B. Frederick
SURGERY	T.J. Beno	L.C. Bernhardt
UROLOGY	D.B. Gute	Vacancy

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of Jan 25, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

CHIPPEWA

Swenson, Franklin H, Rt3 #6, Box 290, Chippewa Falls 54729 (1920, Regular, Therapeutic Radiology, Certified-R)

DODGE

Berry, James S, 707 S University Ave, Beaver Dam 53916 (Orthopedic Surgery, Certified-ORS)
Schroeder, Norman II, 1200 Center St, Beaver Dam 53916 (1949, Regular, Family Physician)

KENOSHA

Ansari, Aftab A, 6530 Sheridan Rd, Kenosha 53140 (1950, Regular, Orthopedic Surgery)
Mendivil, Jairo J, 3618 Eighth Ave, Kenosha 53140 (1944, Regular, General Surgery)
Shewmake, Floyd F Jr, 6530 Sheridan Rd, Kenosha 53140 (1948, Regular, Gastroenterology/Internal Medicine, Certified-IM)

MILWAUKEE

Steiner, Clarence M, 9122 W Center St, Milwaukee 53222 (1905, AMA Age Exempt, General Practice/General Surgery)
Wilson, Stuart D, 8700 W Wisconsin Ave, Milwaukee 53226 (1935, Regular, General Surgery, Certified-GS)

OUTAGAMIE

Kretzschmar, Hanns O, 15 Meadowbrook Ct, Appleton 54911 (1923, Regular, Internal Medicine)

PORTAGE

Numsen, Gene H, 2501 Main St, Stevens Point 54481 (1939, Regular, Pediatrics)

WINNEBAGO

Masangkay, Generoso, Winnebago Health Institute, Winnebago 54985 (1948, Resident, Psychiatry)

CHANGE OF ADDRESS

(Does not include those within a city)

FOND DU LAC

Hutter, Adolph M, Fond du Lac, to PO Box 8340, Madison 53708

MARINETTE-FLORENCE

Rogers, Raymond J, Oconto, to 501 Lakeshore, Lake Park, FL 33403

SHEBOYGAN

Weygandt, James L, Sheboygan Falls, to Kohler Company, Kohler, 53044

WOOD

Vedder, James S, Marshfield, to General Delivery, Anna Maria FL 33501

DEATHS

Landis, Ralph V, Outagamie County, Dec 26, 1978
Lewis, Marian, Milwaukee County, Dec 31, 1978
Scholz, Herbert F W, Milwaukee County, Jan 2, 1979 ■.

Obituaries

◈County, State, AMA Members

◈ **Francis Henry Kehlnhofer, MD,** 70, Wauwatosa physician for 41 years, died Oct 24, 1978 in Wauwatosa. Born June 24, 1908 in Milwaukee, Doctor Kehlnhofer graduated from Marquette University School of Medicine, Milwaukee, in 1935. Doctor Kehlnhofer served as chief-of-staff at St Joseph's Hospital and also was instrumental in the formation of the Sepsis Committee which fought for reforms to combat surgical infections. Surviving are his widow, Mildred; one son, Frank, Brookfield; and two daughters, Kathleen Hackett, El Paso, Tex, and Gayle Kolp of South Milwaukee.

◈ **Henry Arthur Fletcher, MD,** 65, Milwaukee physician for 27 years, died Nov 2, 1978 in Milwaukee. Born Mar 30, 1913 in Grenada, British West Indies, Doctor Fletcher graduated from Howard University School of Medicine, Washington DC, in 1946. He was a member of the American Academy of Family Physicians and the Cream City Medical Society. Surviving are his widow, and two daughters, Carol and Cheryle.

◈ **Richard R Whereatt, MD,** 52, Manitowoc, died Nov 13, 1978 in Manitowoc. Born Aug 15, 1926 in Superior, Wis, Doctor Whereatt graduated from Marquette University School of Medicine in 1954. Doctor Whereatt served as a captain in the United States Army Medical Corps and had practiced in Hammond, Ind, before coming to Manitowoc in 1963. Surviving are his widow, Betty; three daughters, Debbie Stone, West Bend; Cathie Whereatt, Minneapolis, and Nancy Whereatt of Madison.

◈ **Roman E Galasinski MD,** 72, prominent Milwaukee surgeon, died Nov 17, 1978 in Milwaukee. Born Jan 1, 1906 in Milwaukee, Doctor Galasinski graduated from Marquette University School of Medicine in 1931 and practiced medicine in Milwaukee for 40 years. He served in the United States Naval Medical Corps during World War II for 42 months. Doctor Galasinski is a founder and former chief-of-staff of St Luke's and St Francis hospitals, Milwaukee, and also served as chief of surgery at St Luke's and chairman of the Board of Trustees at St Francis. He was past president of the Milwaukee County Medical Society; served as councilor from the 12th district of the State Medical Society of Wisconsin from 1948-1960; and served as a delegate to the Ameri-

can Medical Association from 1960-1975. In 1975 he received the Council Award of the State Medical Society.

Doctor Galasinski was a past president of the Catholic Physicians Guild and the Marquette University Medical Alumni Association. During his career, he was involved in numerous medical and civic organizations that benefitted substantially from his dedicated guidance. Nationally he served on the Advisory Committee for the Heart, Cancer, and Stroke Center and the Presidential Conference on Medicare in Washington DC. He also chaired the AMA Committee on Community Emergency Medical Services.

Surviving are his widow, Florence; a daughter, Phyllis Reimer, Milwaukee, and a son, Charles of Rockford, Ill.

◈ **Glenn Robert Stauff, MD,** 73, Green Bay, died Dec 4, 1978 in Green Bay. Born June 4, 1905 in Milwaukee, Doctor Stauff graduated from Marquette University School of Medicine, Milwaukee, in 1925. Doctor Stauff had practiced medicine in Green Bay from 1932 until he retired in 1973. Surviving are his widow, Mildred; two sons, Louis and Glenn Jr, both of Green Bay; six daughters, Mrs Richard (Mary Ann) Voltz, Lexington, Ky; Mrs Lloyd (Ellen) Van Lanen and Mrs Thomas (Roberta) Conard of DePere; Mrs John (Catherine) O'Brien, Colgate; Mrs William (Clare) Gifford, Danville, Ill, and Mrs Richard (Ann) Trainer, Forest Lake, Minn.

◈ **James E Bercey, MD,** 82, Milwaukee, died Dec 11, 1978 in Milwaukee. Born Feb 19, 1896 in St Martin, Austria-Hungary, Doctor Bercey graduated from Marquette University School of Medicine in 1924. He served as chairman of the Department of Obstetrics and Gynecology at Mt Sinai Medical Center from 1954-1955 and also served in the United States Navy during World War I. Doctor Bercy was active in the formation of the Planned Parenthood program in Milwaukee and also served as consulting physician from 1966 - 1972. Surviving are his widow, Leahbelle; a daughter, Clarice Zucker, Fox Point; and a son, Donald of Lincoln, Neb.

Jacob A Jenner, MD, 84, Milwaukee, died Dec 12, 1978 in Milwaukee. Born Apr 9, 1894, Doctor Jenner graduated from Marquette University School of Medicine, Milwaukee, in 1925. He had practiced medicine in the Milwaukee area for more than 50 years. Surviving are his widow, Louise, and a son, John.

◈ **Otto E Rydell, MD,** 76, Rice Lake, died Dec 18, 1978 in Rice Lake. Born Dec 31, 1901 in Duluth, Minn, he graduated from the University of Wisconsin Medical School in 1928. He had practiced in Rice Lake from 1932 until 1976, and was honored by the University of Wisconsin in 1978 for his 50 years of practice in the medical field. Surviving are two brothers, Dr William, Rice Lake, and Dr John of Santa Barbara, Calif.

◈ **Charles Crottier, MD,** 85, Milwaukee, died Dec 25, 1978 in Milwaukee. Born Jan 12, 1893 in Ishpeming, Mich, Doctor Crottier graduated from Marquette University School of Medicine in 1923. He served with the United States Public Health Service until his retirement in 1968.

◈ **Ralph V Landis, MD,** 81, Appleton, died Dec 26, 1978 in Appleton. Born Aug 29, 1897 in Wakarusa, Ind, Doctor Landis graduated from Rush Medical College, Chicago, in 1924. Doctor Landis served in the United States Army during World Wars I and II. He served as the college physician at Lawrence University from 1926 until 1972 and in 1972, the health center on the university campus was renamed for him. He was a member of the 50-year club of the State Medical Society of Wisconsin. He was a past chief-of-staff at St Elizabeth Hospital and also served on the executive staff from 1942-1972. Surviving are his widow, Pearl; two daughters, Mrs Karl (Ruth) Vollrath, Sheboygan; Mrs Peter (Peggy) Zaecker, Oak Park, Ill; and two sons, Robert K, Billings, Mont; and John R of Appleton.

Raymond Harold Smits, MD, 73, Elm Grove, died Dec 31, 1978 in Elm Grove. Born Mar 25, 1905 in Green Bay, Doctor Smits graduated from Marquette University School of Medicine, Milwaukee, in 1935. Doctor Smits had practiced in West Allis until 1972 when he became a member of the medical staff of the Veterans Administration Hospital at Wood. Surviving are his widow, Marjory; one son, Ronald, Elm Grove; and two daughters, Mrs James (Katherine) Wright, LaFayette, CO, and Mrs. James (Margory) Stuht of Madison.

◈ **Marian Lewis, MD,** 88, retired Bay View physician, died Dec 31, 1978 in Milwaukee. Born Oct 14, 1890 in Milwaukee, Doctor Lewis graduated from Rush Medical College, Chicago, in 1918. Doctor Lewis was affiliated with the Milwaukee Health Department and also was a clinic physician at the Tuberculosis Control Center until her semi-retirement in 1957. She is survived by her sister, Lillian Hobart of Crystal Lake, Ill, and a brother, Marshall of New Auburn.

◈ **Herbert F Scholz, MD,** 82, Mequon city health officer from 1923 - 1958, died Jan 2, 1979 in Port Washington. Born Sept 16, 1896 in Milwaukee, Doctor Scholz graduated from Marquette University School of Medicine in 1921. He maintained a private medical practice from 1923 - 1976. He was a member of the 50-Year Club of the State Medical Society of Wisconsin. Surviving are two daughters, Florence Mattefs, Brookfield; and Lorraine Nelsen, San Clemente, Calif; and a son, Earl of Buffalo, Minn.

◈ **John R Thompson, MD,** 60, former Wautoma physician, died Jan 7, 1979 when the plane he was flying from the West Indies to Miami, Fla, went down in open waters. Born July 21, 1918 in Garrett, Ind, Doctor Thompson graduated from the University of Michigan Medical School in 1944. He served in the United States Marine Corps from 1945 - 1947. Surviving are his mother, Ruth, Tecumseh, Mich, and one sister, Ann, also of Tecumseh, Mich. ■

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Afet Pamukcu, MD,* Kenosha, recently was appointed state director of the Wisconsin American Medical Women's Association. Doctor Pamukcu has practiced medicine in Kenosha since 1965. She graduated from Istanbul University Medical School in 1951 and served her residency at Illinois Masonic Hospital and Cook County General Hospital in Chicago. She returned to Turkey in 1958, entered private practice, and also worked until 1960 in the Ankara American Air Force Hospital. She returned to the United States working in the Boston City Hospital Department of Endocrinology and also joined the Lahey Clinic in Boston. In 1962 she returned to Cook County General and did gastroenterology research at the Hecton Research Institute of Cook County General. She was a fellow in cardiology at Northwestern University Wesley Memorial from 1963-1964. Her husband, Fevzi Pamukcu, MD,* has just completed a term as president of the Kenosha Memorial Hospital medical staff.

Donald Pinkel, MD, former professor and chairman, Department of Pediatrics, Medical College of Wisconsin, Milwaukee, recently was appointed chairman of the Division of Pediatrics at the City of Hope National Medical Center, Duarte, Calif.

Omer Sanan, MD, formerly of Buffalo, NY, recently opened his medical practice in Tomahawk. A graduate from Hacettepe University in Istanbul, Turkey, Doctor Sanan served his internship in Portland, Ore, and completed his residency at the State University of New York in Buffalo.

James L Dean, MD,* formerly with the Dean Clinic, Madison, has joined the medical staff of the Door County Medical Center, Sturgeon Bay. A specialist in obstetrics and gynecology, he had been a member of the Clinic since 1947. While in Madison, Doctor Dean was associated with the University of Wisconsin Medical School Department of Obstetrics and Gynecology.

Paul J Slavik, MD, recently opened his medical practice in Verona. His medical training was taken at St Louis University School of Medicine and at the University of Wisconsin Medical School in Madison. His wife, Kathleen, also is a physician. She is a pediatrician with a special training in genetics, and also took her medical school training at St Louis University. She is an assistant professor at the University of Wisconsin Medical School, Madison.

Carroll M Martin, MD* and **Howard W Short, MD,*** recently joined the medical staff of Kenosha Memorial Hospital. Doctor Martin is a graduate of the University of California Medical School. Prior to coming to Racine, he was on the cardiology staff at Madigan Army Hospital, Tacoma, Wash. Doctor Short graduated from the University of Cincinnati Medical School. He is a clinical instructor in medicine-cardiology and an assistant clinical professor of medicine at the Medical College of Wisconsin-Milwaukee. At the hospital they will interpret electrocardiograms and conduct cardiac stress tests replacing David N Goldstein, MD* who is retiring from active practice.

Anthony Ziebert, MD,* West Allis, has become the chief-of-staff of West Allis Memorial Hospital, replacing Richard Cramer, MD,* West Allis, whose term expired. Doctor Ziebert has assumed the post for two years.

Michael G Marra, MD,* associated with the Amery Clinic for 30 years, has retired. A graduate of the University of Vermont Medical School, Doctor Marra joined the Amery Clinic in 1949. He recently was honored by the community and his friends at an open house in Amery.

Robert E Stelle, MD, senior member of the Falls Clinic PC and chief-of-staff at the Crystal Falls Community Hospital, recently joined the teaching faculty of the University of Wisconsin Medical School as an associate professor of Family Medicine. Doctor Stelle has practiced in the area since 1960. He began his teaching career as associate director of the University of Wisconsin Medical School Family Practice Residency Program in Wausau in January.

James L Weygandt, MD,* Sheboygan Falls, recently joined the Kohler Company medical department as an occupational physician. Doctor Weygandt, who has practiced in the area for 24 years, has been the team physician for Sheboygan Falls High School and also was team physician at Lakeland College. He is a member and past president of the American Association for Automotive Medicine and a medical consultant to the Wisconsin Department of Transportation. Doctor Weygandt also has been a member of the State Medical Society's Committee on Safe Transportation for 20 years, as well as its chairman for 15 years. He is a member of the medical staff of Sheboygan Memorial and St Nicholas hospitals.

James H Glenn, MD,* formerly of Billings, Mont, has joined the medical staff at Calumet Memorial Hospital as a pathologist. Doctor Glenn graduated from Washington University School of Medicine in 1955 and completed his pathology residency at Barnes and City hospitals in St. Louis, Mo. During the past 17 years, Doctor Glenn has been on the medical staff of St Vincent's Hospital in Billings, and also associated with a clinic in Billings.

John F Pederson, MD,* recently became associated with Associates in Laboratory Medicine, a group of pathologists serving St Francis Hospital in LaCrosse. Doctor Pederson graduated from the University of Wisconsin Medical School, Madison, and served his residency at the University of Wisconsin, Madison. Prior to coming to LaCrosse, he spent one year at Howard Young Medical Center in Woodruff.

Edwin W Hoeper, MD,* Marshfield, recently was reelected to a second, two-year term as chief-of-staff of St Joseph's Hospital. Other officers are MDs Guerdon J Coombs, vice chief-of-staff, and Raymond L. Hansen,* secretary. Doctor Hoeper has been a member of the medical staff since 1971.

Nalini Madan, MD, Edgerton, has joined the medical staff of the Shearer-Cohen Clinic in the department of pediatrics. Doctor Madan previously had been at the Children's Hospital in Michigan. She is the wife of Suresh Madan, MD, who is associated with the Orthopedic Clinic in Edgerton.

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City _____ State _____ Zip _____

Dale Sinnett, MD, recently became associated with the Richland Medical Center. A 1975 graduate from Loma Linda Medical School, California, Doctor Sinnett spent his internship and residency at Kettering Medical Center, Kettering, Ohio.

Charles O Miller, MD,* who has been associated with the Medical Center of Monroe since 1955, has joined the medical staff of The Monroe Clinic. Doctor Miller will be at the Brodhead Branch Clinic. The Brodhead Branch Clinic, which opened two years ago, is the first Monroe Clinic satellite to be opened with another scheduled to be constructed in New Glarus this year.

Robert W Long, MD, pathologist and general practitioner, recently joined the clinic of Dr Lynn J Seward,* Berlin. Doctor Long graduated from Marquette University School of Medicine, Milwaukee, in 1961 and completed his residency training at Wayne University, Detroit. He previously had been in practice in St Louis, upper New York, and North Carolina. ■

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1979

1 Subcommittee on Accreditation
2 SMS Physicians Alliance Commission
2 Wisconsin Public Health Association—Legislative Committee
2 *Executive Committee of SMS Council (Madison)*
3 SMS Council
3 SMS Services, Inc
3 SMS Realty Corporation
5 Madison Orthopedic Society
5 Women's Health Issues Planning Committee
6 Dane County Medical Society Board of Trustees
6 WisPRO Liaison Meeting
6 Ad Hoc Committee on Lab Certification
7 Wisconsin Review Foundation (WRF) Board of Directors
7 Health Care Coalition
7 Dane County Medical Society Ad Hoc Committee
8 WisPRO Review and Evaluation Committee
9 SMS Committee on Mental Health
12 Wisconsin Review Foundation Finance Budget Task Force
13 WisPRO Medical Care Evaluation Workshop
14 SMS Commission on Governmental Affairs
14 SMS Committee on Environmental Health
14 SMS Section on Ophthalmology
14 WisPRO Advisory Group
14 "Dept of Health" Committee
15 WisPRO Health Standards Quality Bureau
15 SMS Committee on School Health
16 SMS Commission on Continuing Medical Education
16 WisPRO Continuing Education Committee
16 WisPRO Nominating Committee
19 Women's Health Issues Planning Committee
24 *SMS Leadership Conference (Madison)*
26 Madison Society of OB-GYN

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

A reminder

ZYLOPRIM®

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age. Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular. There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Jackson Clinic, Madison, recently added six physicians to its medical staff. The MDs are Daniel E Britton, neurology; Wendy S Coleman* and Francois M Luyet, pediatrics; Melvin A Churchill, rheumatology; Keith Jantz, internal medicine; and John D Wegenke,* urology.

The Milwaukee Medical Clinic, SC, a 35-physician multispecialty medical clinic, recently elected its Board of Directors for the year 1979. Those MDs elected to the Board are: Walton D Thomas,* president; Edwin G Montgomery Jr, vice-president; Brenton H Field Jr,* secretary-treasurer; Cedor B Aronow, Raphael F Kilcoyne,* and Eugene W Monroe, directors-at-large.

St Elizabeth Hospital, Appleton, has announced the following physicians as its officers for a term of two years. They are MDs Mitchell F Kwaterski,* chief-of-staff; Charles J Green,* secretary-treasurer; and James W Erchul* was named chief-of-staff-elect.

The Sheboygan Clinic, at its annual meeting, announced the following new officers. They are MDs Robert A Wood,* president, succeeding Edward G Schott* who had served as the presiding officer since 1972; Robert T Willis,* vice-president; Earl H Jochimsen,* secretary; and John M Reinemann,* treasurer. Additional members elected at the meeting were Richard B Windsor;* Garry A Quinn,* and James D Michael.* Advisory members to the committee are Paschal A Sciarra* and Rolf L Simsonson.* Doctor Schott, outgoing president, had been a member of the executive board since 1953, and was presented with a resolution of appreciation from the members of the staff for his active participation in the executive management of the Clinic. Organized in 1922, the Clinic has served the community for the past 57 years.

Madison Ear, Nose and Throat Associates recently opened offices in Stoughton. The specialists, MDs John K Scott,* Harold E Manhart,* Willis G McMillan,* and Charles H Mann,* also will be using the facilities of Stoughton Community Hospital. Doctor Scott is a graduate of the Ohio State University College of Medicine and has been board certified in ENT since 1961. Doctor Manhart also earned his medical degree from Ohio State University and has been in practice in Madison for the past 16 years. Doctor McMillan, a native of Winnipeg, Canada, did postgraduate work in ENT at the University of Minnesota, has been in active practice since 1967; and Doctor Mann graduated from West Virginia University and served his residency in otolaryngology at the University of Florida.

Surgical Care-Blue Shield recently announced that Harold M Rose, PhD, was elected Chairman of the Board. He is the first non physician to hold that office. Doctor Rose is chairman of the Department of Urban Affairs at the University of Wisconsin-Milwaukee, and is recognized as an authority on urban problems and socio-economic history and trends among Black Americans.

The American Cancer Society recently granted seven Wisconsin physicians Junior Faculty Clinical Fellowships. The grants are for a one-year period beginning July 1979. Robert Earhart Jr, MD, medical oncologist of the Wisconsin Clinical Cancer Center, Madison, and Diane Norback, MD, pathologist of the Medical School each will receive $10,000; Dennis Citrin, MD, medical oncologist with the Medical School; Richard Love, MD, medical oncologist with the Wisconsin Clinical Cancer Center; and Josh Tunca, MD* who specializes in gynecologic oncology at the Medical School, each will receive $8,000. First-year fellowship grants of $6,000 each will be awarded to Thomas Davis, MD, and Michael Kademian, MD. Doctor Davis, medical oncologist, and Doctor Kademian, radiation oncologist, are on the staff of the University of Wisconsin-Madison Medical School. ■

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Tenuate® ⓒ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

B-3921 (Y587A)

Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® ©IV
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

Merrell

For prescribing information see opposite page.

The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions. However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

© 1975 The Upjohn Company

Motrin 400 mg TABLETS
ibuprofen, Upjohn

The confidence that comes from experience—one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)	
Bottles of 60	NDC 0009-0733-01
Bottles of 500	NDC 0009-0733-02
Motrin Tablets, 400 mg (orange)	
Bottles of 60	NDC 0009-0750-01
Bottles of 500	NDC 0009-0750-02
Unit-dose package of 100	NDC 0009-0750-06
Unit of Use bottles of 120	NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

NIM-3

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ALDOMET®
(METHYLDOPA | MSD)
TABLETS: 500 mg, 250 mg, and 125 mg

WPS

report

for Wisconsin Physicians

Volume VIII, Number 2 March 1979

Recent WPS Activities

WPS Participates in Immunization Campaign

October 1979 represents a deadline for a statewide effort to raise the immunization levels of Wisconsin children above 90 percent as part of the nationwide goal of 90% set by the White House in 1977. The Department of Health and Social Services is directing this campaign, called WINK--Wisconsin Immunization Now for Kids. DHSS is seeking assistance from various groups and organizations to achieve this objective.

Wisconsin Physicians Service has responded to this campaign by entering into an agreement with DHSS to provide financial support for 76 billboards located in selected areas throughout the state for one month to alert the public to immunize their children against childhood diseases. During the time that the billboards will be seen in these cities, public service segments on radio and television will repeat the same message as the billboards. The project is scheduled to begin before the end of February.

By sponsoring this billboard campaign, WPS is reaffirming its public service commitment to encourage better health for Wisconsin citizens. Prior WPS immunization activities have included developing immunization guideline cards--"Let's Get the Kids Vaccinated"--which have been distributed as a health information card for the general public.

WPS Upgrades Computerized Claims Process

During the first week in January, WPS completed installation of new local computer terminals in all areas of claims processing, billing, and analysis. The new terminal resembles a television set with a typewriter keyboard attached, the "typewriter keyboard" being the means for data access and entry. With it, the employee is able to obtain, from storage devices located in the Data Processing Area, necessary information for coverage questions, claims processing, or statistical analysis.

The new IBM Model 3277 Computer Terminal is able to display more data at one time than the previous terminal system. In addition, the IBM 3277 is easier to read, more reliable, and possesses a faster response time than previous models. The total of one hundred new terminals installed is the latest example of the WPS commitment to progressively more efficient claims processing and support activities.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

Physicians Exchange

continued

PHYSICIANS — IMMEDIATE openings nationwide in the following specialties: Internal Medicine, Radiology, Pediatrics, Anesthesiology, Physical Medicine, Orthopedics, Psychiatry, Ophthalmology, General Practice, Emergency Medicine, Gynecology, General Surgery, and many more. Call or write DR PERSONNEL outlining your location and salary. DR PERSONNEL, a nationwide professional personnel service for the health profession, 2040 W Wisconsin Ave, Milwaukee, Wis 53233. Tel: 414/933-7788. 1tfn/78

WANTED: PSYCHIATRIST INterested in part-time work (15-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wis 53705. If interested, please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel: 608/266-1989. 2-5/79

WANTED: FAMILY OR GENeral practitioner to serve East Central Wisconsin small college town of 7,000, close proximity to community hospital with up-to-date facilities. Guaranteed base income with opportunity for partnership. Call or write for details to R S Pelton, MD, 315 Mt Zion Dr, Ripon, Wis 54971. Tel: 414/748-2875. 10tfn/78

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Must be eligible for Oklahoma Licensure.

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Medical Director
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73111

2-4/79

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

PROGRAM/MEDICAL DIRECtor, Physician Assistant Program. Assume leadership of a state-supported, accredited BS degree program. Responsibilities include administration and continuing development of the program. Applicant must be a physician licensed or qualified for licensure in the State of Wisconsin and, preferably board certified or board eligible in a primary care area. Detailed position description available. Contact John L Peterson, Dean, School of Allied Health Professions, University of Wisconsin-Madison, 610 N Walnut St, Madison, WI 53706. Tel: 608/263-6800. EOE. 3-4/79

FAMILY PRACTITIONERS: two young, board certified family physicians seek one or two board eligible or board certified family practitioners to join busy, three man group (one member leaving) in Watertown, Wisconsin, a community of 18,000, located within one hour of Madison and Milwaukee. Immediate opening. Guaranteed income. If interested, contact Watertown Family Practice Associates, 123 Hospital Drive, Watertown, Wis 53094. Tel: 414/261-8500. 6tfn/78

MULTISPECIALTY GROUP OF 29 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

WANTED: ORTHOPEDIST INterested in part-time work (15-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wis 53705. If interested, please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel. 608/266-1989. 2-5/79

WANTED: GENERAL SURgeon and family practice physician to join a group of nine family practitioners, one general internist in a rural community in northwestern Wisconsin. For additional information, contact Lloyd Cotts, MD, Rice Lake, Wis. Tel: 715/234-9031. 2-4/79

FAMILY PHYSICIAN: WAUSAU to join three board certified ABFP physicians. New medical office opened March 1978 and new hospital to open in 1979. Contact: R E Cadwell, MD, 212 Sturgeon Eddy Rd, Wausau, Wis 54401. Tel: 715-842-0491. 10tfn/78

THE WAUSAU MEDICAL CENter, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology
- Dermatology
- Family Practice for satellite clinic
- Neurology
- Otolaryngology
- Thoracic Surgery with Peripheral-Vascular Surgery

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, write John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 3tfn/79

THREE YOUNG FAMILY PHYsicians need fourth man in college community of 80,000 in Southeastern Wisconsin. Two general hospitals with a total of 700 beds. Salary and fringe benefits first year—partnership thereafter. Contact Dept. 421 in care of the journal. 9tfn/74

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

PHYSICIAN TO DIRECT new program unit; employer is State of Wisconsin, Division of Health. Position will involve directing a staff in investigations and epidemiologic studies of illnesses caused by exposure to toxic substances and carcinogens. We have formal organization linkages with the University of Wisconsin. A joint appointment with the UW-Department of Preventive Medicine can be arranged. Salary dependent upon experience and board certifications. If interested, call Ivan Imm (608) 266-1251 or write to Bureau of Prevention, Room 453, 1 West Wilson St, Madison, Wis 53702. 3/79

Physicians Exchange

continued

EMERGENCY PHYSICIAN WANTED to join established 4-man group at Madison General Hospital in Madison, Wisconsin, the State Capitol and home of the University of Wisconsin. Great place to live. Salary plus benefits. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 3tf/79

FAMILY PHYSICIAN WANTED to join two-man group. Excellent opportunity. Contact: John R Goelz, MD, 519 S Monroe Ave, Green Bay, WI 54301; 414/437-5431. p3/79

OUR FAMILY PRACTICE group seeks another associate to join us in one of the most desirable recreation areas in northern Wisconsin. We offer an excellent consulting staff of specialists within our group and a new 110-bed hospital next door. We prefer a board eligible or certified family physician. Call or write us if you are interested in this unique opportunity at Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, Wis 54568. Tel: 715/356-3292. 1-3/79

FAMILY PHYSICIAN NEEDED to join six-man group of four family physicians, one surgeon and one internist. There is an 80-bed hospital, well-equipped and major referral center 20 minutes away. Town of 9,500 with an economy based on agriculture and a small manufacturing. Located north of the crowds and south of the tourists. Excellent outdoor sport within minutes. Contact: G C Kloster, MD, 1205 O'Day St, Merrill, Wis 54452. Tel: 715/536-9511. 1-3/79

WANTED: ORTHOPEDIC SURGEON, Board certified or eligible to join nine man group consisting of 8 family practitioners and general surgeon in University town with trade area population of 22,000, 30 miles southeast of St Paul, MN. JCAH approved hospital. Contact Roland M Hammer, MD, River Falls Medical Clinic, Ltd, River Falls, WI 54022, or call collect 715/425-6701. 2tfn/79

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS

is a non-dues-paying organization of PHYSICIANS AND DENTISTS who get together at least yearly to help each other obtain and maintain their sobriety and freedom from drugs. The next annual convention will be held August 2-5 at Holiday Inn, at the Embarcadero, 1355 North Harbor Dr, San Diego, CA 92101 (specify IDAA Meeting) or call 800/453-5555. For further information, contact Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511. Tel: 216/782-6216. g2/79

Medical Facilities

MEDICAL CLINIC SPACE available. Janesville Road and Pioneer Drive, Muskego. 2,500 sq ft on ground floor. Modern, move-in condition. Please contact: Roger Bothe, John Herschede & Associates, Inc. Tel: 414/933-0585. 7tfn/78

FOR SALE: LIKE NEW MEDICAL Clinic located in a friendly S/W Wisconsin community. Over 4000 sq ft on ground floor. Ideal for a small group that wants to earn while they own. Terms possible at $179,000. Ask for Don Anderson, 608/256-4288, CENTURY 21 City Wide Realty, 608/238-7333. 1-3/79

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOND DU LAC FACILITY. Complete medical practice suite available soon. Suitable for group practice of five or six, or a pair and three. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

FOR SALE: PHYSICIANS SUITE and practice, full-equipped in medical building. Ideal for general practice or internal medicine. 5148 N Teutonia Ave, Milwaukee. Three blocks from St Michael's Hospital. Call Art Smith 414/462-7570 or 414/464-7240, or evenings contact Mrs Duffy 414/352-4469. g5tfn/78

FOR SALE: PHYSICIAN AND surgeon deceased. Lovely lannon stone home and two doctor offices with x-ray, consultation drug room, large waiting room and business office, and private offices in A condition with two-car garage. Call 414/863-2106. g2tfn/79

Practices Available

AVAILABLE: MARCH 1979 ESTABLISHED medical practice and equipped office and records. Suitable for solo or group. Will lease. South side of Milwaukee. Tel: 414/352-9736. 1tfn/79

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64th Scientific Assembly
Interstate Postgraduate Medical Association of North America

November 5-8, 1979
New Orleans Marriott
New Orleans, Louisiana

Program Highlights

INFECTIOUS DISEASES—Why antibiotics don't work, by Ray DeHaan, MD, Kalamazoo, Mich, update on antibiotics, by George Pankey, MD, New Orleans, La; Prevention-Immunization-antiviral drugs, by F Robert Fekety, MD, Ann Arbor, Mich.

CHRONIC PAIN—When all else fails in the treatment of osteoarthritis, by Joseph L Hollander, MD, Philadelphia, Pa; Chronic pain and prostaglandins, by Robert B Zurier, Farmington, Conn; Pain centers, by Steven F Brena, MD, Atlanta, Ga.

NUTRITION — Nutritional panel, by Trenton L James, Baton Rouge, La.

GASTROENTEROLOGY — Nonmalignant lower "GI" problems, by William Davis, MD, New Orleans, La; Viral hepatitis, by John A Bryan, Atlanta, Ga; Upper "GI" problems.

ENDOCRINOLOGY — Insulin vs oral hypoglycemics, by Stefan S Fajans, MD, Ann Arbor, Mich and David M Kipnis, MD, St Louis, Mo; Controversies in estrogen therapy, by Robert Greenblatt, MD, Augusta, Ga.

CARDIOLOGY — Coronary artery disease; Latest feedback from the Framington study; Lowering cholesterol, triglycerides and lipids, by George Mann, MD, Nashville, Tenn, Anticoagulants, by C Thorpe Ray, MD, New Orleans, La; Elevated blood pressure, by Ray W Gifford, MD, Boston, Mass; Nutrition, by Fredrick Stare, MD, Boston, Mass; Management of carotid bruit (Oschner Lecture), by John Oschner, MD, New Orleans, La.

UPDATE ON CURRENT TRENDS AND TECHNOLOGY—Headaches, by Seymour Diamond, Chicago, Ill; Blood gases, by William Waring, New Orleans, La; New lab techniques that are cost-effective, by M Desmond Burke, MD, Minneapolis, Minn; Cost containment, by John H Budd, MD, Cleveland, Ohio; Medical and medicinal causes of impotence, by Fletcher C Derrick, Jr, MD, Charleston, SC; and Sexual dysfunction, by Sandra Cole, MD, Theodore Cole, MD, Ann Arbor, Mich.

SUBJECTS FOR LIVE CLOSED CIRCUIT TELEVISION
—Sports medicine
—Office dermatology (including minor surgical procedures)
—Neurological problems
—Well infant and child exam
—Management of back pain
—Foot and leg problems (varicose vein and/or leg ulcers)

Registration fee: $100. 24 hours credit toward PRA-AMA and AAFP, applied for. Also 4 hours credit in Category 5 PRA-AMA. Credits also applied for through Canadian Medical Association.

Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701; phone 608/257-6781, ext 105.

1979 Neighboring

continued

versity Services, School of Continuing Education, Central Michigan University, Mt Pleasant, Mich 48859; phone 517/774-3715, ext 277. g2-3/79

Apr 21-22: Iowa State Medical Society Annual Meeting, Des Moines. Info: Exec V-P: EE Huston, 1001 Grand Ave, West Des Moines, Ia 50265.

American Holistic Medical Association

International Conference

EXPLORING THE DIMENSIONS OF SCIENTIFIC MEDICINE

May 18-24, 1979

University of Wisconsin at LaCrosse

Over 50 presentations plus in-depth experimental workshops related to stress control and High Level Wellness. Special Medical Deans' Panel—5 Deans will discuss current extent of Science in Medicine. 444 hours of Category 1, CME. CO-SPONSORS: St Francis Hospital—LaCrosse; American Society of Contemporary Medicine and Surgery; Biogenic Institutes of ´America.

Contact: AHMA, Rt 2, Welsh Coulee, La Crosse, WI 54601. Tel: 608/786-0611
3-4/79

1979 Others

Nov 5-8: 64th Scientific Assembly of Interstate Postgraduate Medical Association of North America, New Orleans Marriott, New Orleans, La. Info: IPMANA, PO Box 1109, Madison, Wis 53701.

Statewide Conference on Women's Health Issues

Cosponsored by the State Medical Society of Wisconsin and the Governor's Commission on the Status of Women

Monday, April 23, 1979
Sheraton Inn—Madison

The conference will focus on the sensitivity of the health care system toward women and ways to make it more responsive to their needs.

"This will be the first time in Wisconsin that both consumers and providers of health care will meet together to assess the special health needs of women," says Kathryn Clarenbach, chairperson of the Commission on the Status of Women.

"We want the issues to be raised so we can understand the problems and begin to correct them," says Jules D Levin, MD, president of the State Medical Society.

Recommendations from the conference will be presented to physicians at the State Medical Society Annual Meeting in Milwaukee May 10-12.

Workshops on . . .
—Women's Rights and Responsibilities as Patients
—Birth Control and Unplanned Pregnancy
—Maintaining Health During Pregnancy and Childbirth
—Women's Health in the Middle Years and Beyond
—Use and Abuse of Alcohol and Other Drugs
—Women and Surgery—What are the Choices?
—Mental Health

The conference is aimed at the consumers of health care and is open to the general public but registration is limited. Registration fee: $15. For further information, contact the Health Services Division, State Medical Society of Wisconsin, 330 East Lakeside Street, PO Box 1109, Madison, Wis 53701; or phone toll-free 1-800-362-9080.

Health Planning and the Physician

A two-day conference on health planning, its effect on medical practice, and the potential for physician involvement

Friday-Saturday / June 8-9 / Concourse Hotel / Madison

PROGRAM

Friday, June 8, 1979

8:30 a.m. — Welcoming Remarks

IRST SESSION: The Reasons for Health Planning

8:45 a.m. — Introduction

An overview of the social, economic and political factors that precipitated the health planning mandates.

9:00 a.m. — PANEL: Controlling Health Care Costs

A look at recent trends in health care costs, attempts by government to control these costs, and their impact on both consumers and providers.

9:45 a.m. — PANEL: Assuring the Quality of Care

A discussion of the attempts made by the public and private sectors to assure quality in the delivery of health care. This panel will assess the effectiveness of these efforts from the provider and the consumer perspective and will relate quality concerns to current health planning mandates.

0:30 a.m. — Coffee Break

0:45 a.m. — PANEL: Providing Accessible Health Care Services

An examination of health manpower needs and the degree to which the health care system inhibits or facilitates the ability of an individual to gain entry and to receive services.

1:30 a.m. — PANEL: Preventing Duplication of Health Services

To what extent are health care services, facilities, and equipment duplicated in the health system? Panel members will evaluate the impact of duplication in terms of cost, quality and access to care, and government attempts to prevent it.

2:30 p.m. — Lunch

ECOND SESSION: The Health Planning Mandates

2:00 p.m. — PANEL: Review of Federal Health Planning Legislation and Regulations

A review of the provisions of P.L. 93-641, the National Health Planning and Resources Development Act and 42 CFR, the National Guidelines for Health Planning.

3:15 p.m. — Break

3:30 p.m. — PANEL: Implementation of Health Planning Mandates in Wisconsin

A discussion of the health planning process in Wisconsin, and the roles the Health Policy Council, Health Systems Agencies and the State Division of Health have in this process. Specific programs such as certificate-of-need, appropriateness review, and decertification will also be highlighted.

6:00 p.m. — Cocktail Reception

7:00 p.m. — Dinner

Keynote Speaker: U.S. Senator Gaylord Nelson (invited)

Saturday, June 9, 1979

THIRD SESSION: Provider Power! Involvement in the Health Planning Process

8:30 a.m. — Coffee and rolls

8:45 a.m. — Introduction

9:00 a.m. — PANEL: The Wisconsin Physicians Planning Network — A State Medical Society Approach

The Wisconsin Physicians Planning Network is designed to promote active physician participation in the health planning process. The network will parallel the existing structure and offer physicians a mechanism through which they can effectively influence health planning decisions.

11:00 a.m. — PANEL: From the Planners' Perspective — Suggestions for Provider Involvement in Health Planning

Health planners will outline a format for physician input which would be useful to them in formulating realistic, workable plans.

11:45 a.m. — Conference Overview

12:00 p.m. — Lunch

Panel participants will include health care professionals from government, academia and the provider community and consumer representatives.

Presented by the State Medical Society of Wisconsin as a membership benefit

---------- PRE-REGISTRATION FORM ----------

am interested in attending the State Medical Society of Wisconsin Health Planning Conference. Please send me registration nformation.

IAME _____

ADDRESS _____
Street City State Zip

ELEPHONE (Office) _____

Return this form to:

State Medical Society of Wisconsin
Health Services Division
P.O. Box 1109
Madison, WI 53701

Or call in Madison 257-6781, toll-free 1-800-362-9080

News You Can Use

New officers of the Wisconsin Medical Examining Board for the year 1979 have been announced as follows: William Baker, MD, Monroe, chairman; Nelson Moffat, MD, Marshfield, vice-chairman; and Mary Reddin, Milwaukee (public member), secretary.

The 1978-79 registry of physicians, physical therapists, podiatrists, and physician's assistants is now available for distribution, according to Deanna Zychowski, executive secretary of the Wisconsin Medical Examining Board. The cost per copy is $3.12 and checks should be made payable to the Wisconsin Medical Examining Board, 1400 East Washington Ave, Madison, Wis 53702. Physicians will no longer receive a complimentary copy due to a recent change in the Statutes requiring that the Board now charge for this registry.

The Division of Health's Bureau of Prevention is looking for a physician to direct a new program unit involving the direction of staff in investigations and epidemiologic studies of illnesses caused by exposure to toxic substances and carcinogens. See further details in the YELLOW PAGES, Physicians Exchange columns, of this issue.

Medical care, doctors' fees lag behind rising living costs. Inflation in the general economy exceeded the rise in medical costs over the past year, according to the US Bureau of Labor Statistics release recently. The all-items component of the Consumer Price Index rose 8.6% in the same period, and physicians' fees rose only 7.8%. The CPI figures are seasonally adjusted.

Seminar planned on adolescent sexuality. The Universtiy of Wisconsin-LaCrosse and the UW-Extension are sponsoring a two-day seminar on adolescent sexuality, April 20 and 21, in LaCrosse. The seminar, entitled "How to Make Decisions About A Subject That's Hard to Make Decisions About," is designed for physicians, other health professionals, teachers, and the community. Topics will include an overview of adolescent development and sexuality; adolescent legal issues; communicating with teenagers about sexuality; sexual attitudes and behavior, adult sexuality-parenting, family life education-proposals for solutions to teenage pregnancy problem. The program is acceptable for 12 hours of Category I credit for the Physicians Recognition Award of the American Medical Association. For more information contact UW-LaCrosse at (608) 785-8900.

Symposium on compulsory health insurance slated. April 30 is the date for "Compulsory Health Insurance: The American Debate" a symposium being sponsored by UW Center for Health Sciences, Department of the History of Medicine. Topics on the program include: "The Right to Health Care: The Evolution of an Idea;" "Compulsory Health Insurance: Origins and Transmission;" "The Cost of Medical Care: History and Prospects;" "American Physicians and Compulsory Health Insurance;" "The British Influence: Lessons of National Health Insurance," and "The Medicare Experience." Physicians attending this program may receive six hours Category I Continuing Medical Education credit toward the Physician's Recognition Award of the American Medical Association. For more information contact: Dept of the History of Medicine, 1305 Linden Drive, University of Wisconsin, Madison, Wis 53706; (608) 262-1460. ■

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STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

APRIL 1979

• Unified membership: To be or not to be • *In perspective:* AMA's "Health Effects of Energy Generating Sources" position questioned • New CON thresholds worked out by SMS/DHSS • State DHSS finalizes Super-Rule • Jail health care in Wisconsin • Annual Meeting timetable of events and scientific program • Maternal mortality • Council actions

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URINARY TRACT INFECTIONS

PNEUMOCYSTIS CARINII PNEUMONITIS

SHIGELLOSIS

ACUTE OTITIS MEDIA

*Involving susceptible organisms.

Please see Indications section in summary of product information on last page of this advertisement.

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ROCHE INTRODUCES

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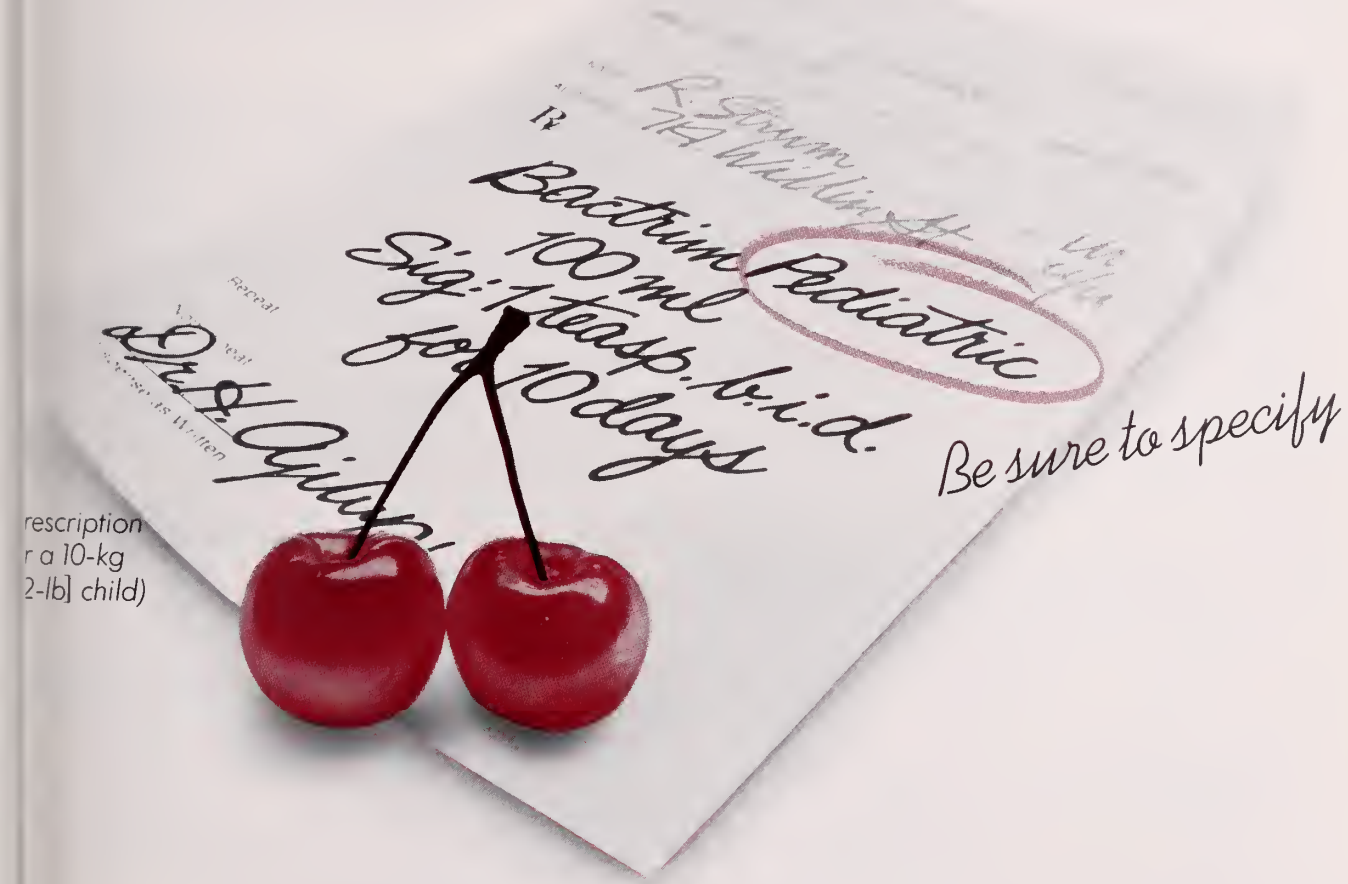

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Also available: The original fruit-licorice flavor to be prescribed
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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides, pregnancy, nursing mothers, infants less than two months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis. A guide follows.
Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
22	10	1 teasp. (5 ml)	½ tablet
44	20	2 teasp. (10 ml)	1 tablet
66	30	3 teasp. (15 ml)	1½ tablets
88	40	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole: bottles of 100, Tel-E-Dose® packages of 100, Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 40, available singly and in trays of 10. *Pediatric Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole: cherry flavored—bottles of 16 oz (1 pint). *Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

April, 1979 Meetings

April 4–7 **Tennessee Medical Association**
Airport Milton Inn
Memphis, Tennessee

April 19–21 **Alabama Medical Association**
Birmingham Hyatt House, Civic Cent
Birmingham, Alabama

April 19–22 **Missouri State Medical Associatior**
Chase-Park Plaza Hotel
St. Louis, Missouri

April 20–22 **Georgia Medical Association**
De Soto Hilton
Savannah, Georgia

April 21–22 **Iowa Medical Society**
Hyatt House
Des Moines, Iowa

April 22–25 **Arkansas Medical Society**
Little Rock Convention Center
Little Rock, Arkansas

April 25–29 **Arizona Medical Association**
Safari Hotel
Scottsdale, Arizona

April 26–29 **South Carolina Medical Associatio**
Myrtle Beach Hilton
Myrtle Beach, South Carolina

April 29–May 2 **Nebraska Medical Association**
Holiday Inn
Kearney, Nebraska

Front Page Update

Annual Meeting time approaching: May 10-12. The 1979 Annual Meeting of the State Medical Society of Wisconsin will be held May 10-11-12 in Milwaukee at the MECCA and Marc Plaza. The House of Delegates sessions are scheduled for Thursday, May 10, at 2 p.m.; Friday, May 11, at 4 pm; and Saturday, May 12, at 8 am at MECCA. A summary of the resolutions to be presented to the House appeared in the March issue of *WMJ,* as well as biographical data on the nominees for offices. There are many special programs planned for Friday with the specialty sections and societies having their programs on Saturday. Complete programs were mailed to members early in April. A concise listing of the Annual Meeting Program appears in this issue. For further information contact Bill Wendle, Scientific Affairs Coordinator in the Health Services Division, at SMS offices in Madison: 257-6781 or toll-free 1-800-362-9080.

Jail health care in Wisconsin. In this issue there appears an indepth report of the State Medical Society's involvement in the National Jail Health Care Project established by the AMA. The Project's objectives are to improve health services in county jails, with the major effort being the establishment of standards of health care for accreditation of county jails by the AMA. During the three years of SMS participation, there have been four county jails accredited, 12 others are involved in the accreditation process, and there is mounting interest from other county jails. The Project also has produced at least two incidental benefits: An improved rapport among physicians, other health care providers, county sheriffs, jail personnel, and the community; and cost savings.

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Category I CME credits accumulated since January 1, 1977 can be reported. A receipt from the sponsoring organization indicating its name, your name, the number of hours completed, and Category I approval by either the AMA or the AOA is required. Proof of CME credits must be sent by December 1, 1979 to:

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. . . or you won't have a license to practice medicine in 1980. If you have questions or concerns, call the State Medical Society Health Services Division: 608/257-6781 (Madison area) or toll-free 1-800/362-9080. ■

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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9 SMS Committee on Mental Health
9 SMS Committee on Maternal and Child Health
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14 SMS Committee on Environmental Health
14 SMS Committee on Federal Legislation
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COMPLETE ANNUAL MEETING PROGRAM

Early in April SMS members were sent the complete 1979 Annual Meeting Program. Please refer to this Program for further particulars. Anyone wishing an additional Program may call the SMS offices on the toll-free In-WATS line: 1-800-362-9080 (calls must originate in Wisconsin). Physicians are requested to bring their Annual Meeting Programs with them. Also the timetable of special events and scientific program appearing elsewhere in this issue can be clipped and placed with the PROGRAM for a concise outline of the scheduled times for each event.

STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

Unified membership: To be or not to be

As the doubt-ridden-Hamlet pondered his future, to exist or to destroy himself, so the House of Delegates of the State Medical Society also will ponder its future in May 1979 when the unified membership rule is again debated. All of our members have already pondered this, some deeply and others casually. Many have expressed their opinions in the recent surveys sent out by the State Medical Society and Milwaukee County Medical Society. Most of us are familiar with the results of these surveys. The Council of the State Medical Society, in response to its survey, has submitted a resolution to the House of Delegates for its consideration, calling for an amendment to the Constitution of the State Medical Society to break the unified membership rule. If passed, it will mean that members of the State Medical Society will not have to be members of the American Medical Association.

In these calm, reflective moments in the dead of winter, with temperatures below zero and snow blanketing the landscape, it is time for each of us to weigh the risks and benefits versus the liabilities of such a course of action and to delve deeply into our consciences about the wisdom of each course of action. We also should look at this entire problem and place it into the context of other successful organized movements in this country in which we have the privilege of living.

Many will opt for discontinuing our association with the AMA because they do not feel it truly represents us. Others may say that the dues and benefits derived are not commensurate. Still others will say that they cannot in conscience support an organization with which they totally disagree in regard to its policies, whether it has to do with medical care, its relationship with the government or society or with medical ethics (*eg,* chiropractors, abortion, etc).

On the other hand, many will contend that in unity there is strength. They will point to the success of organized labor over the past 100 years. They will point out the impoverished conditions of the laboring force immediately following the Civil War and how it was exploited by the vested interests of rampant capitalism, the "captains" of industry, the robber barons. It was only through the arduous efforts by organized labor over the last 90 years that the lot of the working man has been improved. The working man had to fight for his place in the sun and he attained his goal through organized unionism. It is a lesson that many of us should remember. The worker saw the benefits of organization and unity and grasped the quintessential core of its reason for importance; *viz,* political power where it could make its demands be translated into law for the benefit of the working class. Can this lesson of history in our own time be lost upon us who are pondering our future?

We on the state level can see the power of organization of small groups; *eg,* the chiropractors. On a national level, they are just as effective in achieving their goals. While medical societies are showing signs of fragmentation, other groups are showing signs of increased effectiveness of organization and power. In my opinion this is not the time for individual physicians or county medical societies to lessen their effectiveness by splitting off from their parent organization, despite the reasons set forth for doing so. Such a course of action will lead to further disintegration and dissipation of our energies and efforts.

Does an individual citizen resign from his country because he differs from some of its policies? If he does, where does he go? Does a member of a family resign from his family because of a disagreement? If so, where does he go? Does a physician or an organization resign from a parent organization? If so, where does the individual of a medical society go? Many will give different answers to these queries; but the citizen, family member, physician, or medical society would be much better and stronger if they stuck together and worked for the good of the whole.

If only physicians would return to fundamental principles, remember the idealism of their youth; if only they would take the long philosophical

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

view that history teaches us; if only they would give their loyalty, their time, and financial support to their medical society. Commitment to the medical society is not too much to ask of any physician. I am afraid that many physicians are too isolated, narrow minded, and too self-centered to see anything beyond their own family and practice. Unfortunately they "have eyes to see, and they see not." They "have ears to hear, and they hear not." If this situation continues much longer, these very physicians will be the victims of their own apathy and discontent as the many forces arrayed against organized medicine gain continued victories over us and reduce the profession to that of mere technicians and servants of the state.—JPM

New Editorial Board member

THE COUNCIL OF THE State Medical Society at its February meeting appointed Harlan M Levin, MD of Janesville to the Editorial Board. Doctor Levin, a dermatologist, is a graduate of Harvard College and the University of Chicago Medical School. He also is a retired Colonel, MC-USAR. He has written rather extensively himself and the other members of the Editorial Board and the staff of the *Wisconsin Medical Journal* welcome Doctor Levin to the fold.

Doctor Levin is replacing Doctor Garrett Cooper. At the same meeting of the Council, Doctor Cooper was made an emeritus member of the Editorial Board of the *Wisconsin Medical Journal* "in recognition of his long service and deep interest in the presentation of a journal which has maintained high standards of scientific excellence throughout its history." The Council went on to extend its heartfelt appreciation for Doctor Cooper's great service to Wisconsin medicine.—VSF

Maternal mortality

IN THIS ISSUE of the *Wisconsin Medical Journal* there appears the first of a series of obstetrical briefs. This one on maternal mortality is a thoughtful and retrospective presentation by Dr Frederick J Hofmeister. He has long been active with the Wisconsin Maternal Mortality Study Committee and this present study goes back to 1934.

The figures from the early years are depressing and the marked improvement in later years merits a commendation for the obstetricians in the state and to the dedicated study committee.

Doctor Hofmeister points out that even in 1979 mothers die and infants die and his warning to physicians in obstetrics must be heeded.—VSF ■

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Opinion/Dialogue

Truth in advertising

I HAVE SOME CONCERNS about the present antismoking campaign. It is not that I feel smoking, and particularly cigarette smoking, is not detrimental to good health. While direct evidence of cause and effect between cigarette smoking and cancer of the lung is lacking, certainly the circumstantial evidence is overwhelming. However, with all these points in view, I think those directing the antismoking campaign are bordering on scare tactics and are stretching the truth. Seldom does one see the fact that only five percent of heavy smokers develop cancer of the lung. The implication that all heavy cigarette smokers will develop emphysema, cancer or heart disease is not precisely true. People who do not smoke also develop cancer of the lung, emphysema and heart disease. The most recent TV ad indicates that cigarette smoking causes cancer, emphysema, and heart disease. The implication is that it is the sole cause and if you do not smoke you will not develop these diseases. I will not debate that cigarette smoking is a very significant contributing factor, but I would suggest that those directing the antismoking campaign keep their mass media information within the realm of reality and closely related to fact rather than fantasy. The effect of not doing so will be a loss of credibility.

RICHARD D SAUTTER, MD
Marshfield, Wisconsin

The PA—a status report

IN THIS ERA OF increasing demands on physicians' time and energies, the role of the physician extender is becoming ever more apparent and justified. These allied health personnel assume several forms, but most are either licensed physician assistants (PAs) or nurse practitioners (NPs). The continued wave of required routine examinations, our increasing mandate to carry on preventive medicine, and the increasing tendency for patients to require more and more services make it ever more difficult for the primary-care physician to be all things to all people at all times.

As early as 1961, the AMA's Council on Medical Education recognized the need for "an advanced medical assistant with special training, intermediate between that of the technicians and the doctor, who could handle not only many technical procedures but also could take some degree of medical responsibility." Several organizations thereafter carried out independent studies and made recommendations so that by 1971 the Council had defined the services PAs could perform in broad terms and set out tentative standards for their education and training. This culminated in the formation of the Joint Review Committee on Educational Programs for Physicians Assistants which is now made up of six sponsoring organizations (American Society of Internal Medicine, American Academy of Pediatrics, American College of Surgeons, American College of Physicians, American Academy of Family Physicians, and American Association of Physicians Assistants). This impressively credentialed body has since accredited 53 allied health personnel training programs, and at present has accounted for licensure mechanisms for PAs in at least 44 states. Wisconsin has 127 licensed PAs as of December 1977 and the training programs are growing.

Although many physicians think of the PA as someone who performs only in geographical areas of gross physician shortage, in reality the PAs are playing an ever expanding role in urban and suburban as well as rural settings. They have been found to be effective and useful in both office and hospital settings, on house calls and in nursing homes, and to a large extent have demonstrated a great deal of patient acceptance. It has been suggested that 80 percent of everyday office problems can adequately be handled by a PA working under the supervision of a physician.

What does all this mean? It portends of increasing use by the PA in a variety of settings, and those physicians who have closed their minds to the legitimacy of the PA must rethink their reasons and motives. It also means that physicians using PAs must remain ever alert to their responsibility to maintain adequate communica-

tions with the PA and supervision of PAs' activities.

The six sponsoring organizations are well aware of the potential dangers involved and are carrying on continued efforts at establishing adequate review mechanisms of PA usage. At the root of it all is the bottom line principle that some type of physician supervision is essential. Proper definition of that supervision must continue to be striven for and will likely change with time and expanded usage of the PA. The inferred corollary suggests that the PAs themselves recognize their vulnerable position in the medical community and continue their excellent record of striving at all times to put their best foot forward.

PHILIP J DOUGHERTY, MD
Menomonee Falls, Wisconsin ■

Letters

WMJ plaudits

CONSIDERING THE MYRIAD of challenges facing medicine today there is no doubt but that effective communication is essential . . . both within the membership of the federation of organized medicine and in the public forum. Obviously, membership communication is the most critical inasmuch as it impacts heavily upon the external effort.

As a person who sees most of the state journals and regularly scans the publications of state and county societies in 17 states I can tell you that the *Wisconsin Medical Journal* is undoubtably one of the finest in the nation. The judicious blend of technical, socio-economic, and general interest information combined with expertly conceived layout and design makes the Journal excellent reading. With such a fine publication available to them there is no excuse for any Wisconsin physician failing to be informed on the issues of importance to his or her career.

My observations are based, in addition to my current involvement with medicine as an association executive, upon more than a dozen years as a newspaper editor and seven as a management consultant in communications to private corporations, including four Fortune 500 firms.

JAMES S KOSMO
Assistant Director
Public Affairs Division
American Medical Association
Chicago, Illinois

I READ THE EDITORIAL in the December issue of the *Wisconsin Medical Journal* with dismay. I agree that the Journal is too young to die. Kindly let me know what I might do to help with regard to your endeavors to continue to publish the Journal in its present format.

HARVEY L BARASH, MD
Madison, Wisconsin

YOU, DOCTOR FALK, and your staff have done a good job over the years, and I would expect will continue . . . and now that we have probably 1000 or more medical faculty members at the Wisconsin medical schools (Madison and Milwaukee)—a generous source of scientific papers will be forthcoming, to benefit of not only Wisconsin physicians but also medicine throughout the United States and the world. This most easily would bring stature to the *Wisconsin Medical Journal.*

MAURICE HARDGROVE, MD
Milwaukee, Wisconsin

SMS Life Membership

IT IS WITH DEEP appreciation and many thanks that I wish to acknowledge the receipt of the plaque of Life Membership in the State Medical Society of Wisconsin. In particular, I have been touched by the thoughtful expression of your (Secretary Earl Thayer) personal reflections and congratulations. With deep humility and with utmost loyalty to the lofty traditions of the State Medical Society of Wisconsin, I shall cherish this accolade of my professional career as long as I shall live. With my kindest regards and with all of my best wishes to you and to Doctors Levin and Haskins.

ANDREW L BANYAI, MD
St Petersburg, Florida ■

In Perspective

Editor: BRIAN JENSEN
Director, Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

AMA's "Health Effects of Energy Generating Sources" position questioned

THE STATE MEDICAL SOCIETY'S Committee on Environmental Health was established in late 1977 to assist the Society in responding to problems dealing with health and the environment. The committee is composed of nine physicians and a representative of the SMS Auxiliary. Physician-members of this committee are representative of such environmentally related specialties as genetics, neurology, and pulmonary disease. In our year and a half of existence, we have deliberated on the 1978 State Health Plan and considered various legislative bills, some of which have been recommended for State Medical Society endorsement. On one occasion we have acted as an open forum to allow a Wisconsin physician to air an environmental problem in her community.

Our committee has some serious misgivings about a position taken by the AMA House of Delegates in regard to the health effects caused by the various sources of electrical generation. The AMA's Council on Scientific Affairs recently published its study, "Health Effects of Energy Generating Sources," which concluded that the adverse health effects of coal were several hundred times greater than those of nuclear generated electricity.[1]

Although "Health Effects" was approved by the AMA House of Delegates,[2] there was little discussion on this controversial subject, which was not considered in depth. The nuclear industry has been quick to take advantage of the House of Delegates' action to use it in advertisements to support nuclear power as means of generating electricity. In essence, we find the AMA's prestige being used to promote nuclear power, an industry besieged with serious problems which as of yet have no ready solutions.

The Environmental Health Committee has analyzed "Health Effects" and has found the study deficient in many respects and invalid in its conclusions. The AMA study is based on a limited number of statistical references from sources which traditionally have promoted nuclear power.[3]

The study legitimately identifies mine safety and silicosis as health problems directly concerned with our consumption of electricity generated by coal. However, notably lacking, are any statistics on nuclear safety, although statistics have been available since 1977.[4] Reactor safety again has come under serious questioning with the Nuclear Regulatory Commission's recent withdrawal of its endorsement of its own "Reactor Safety Study" (Rasmussen Report) on Jan 19, 1979. The Council on Scientific Affair's study dismissed a serious nuclear accident merely as an event of very low probability.

The Council's study correctly incorporates the noxious air emissions of coal-fired plants as the cause of serious health effects in many areas of the country. Although nuclear waste is a significant threat to the public health on both ends of the nuclear fuel cycle, we find little mention of these problems in "Health Effects." There can be little doubt that health effects are already occurring from the 140 million tons of uranium mine tailings which lie exposed in Western United States.[5] According to the American Physical Society, the tailings become the dominant health effect of the nuclear fuel cycle after 1000 years.[6] Uncertainty as to the method of disposition of spent fuel rods does not presently allow us to assess health effects from the spent fuel rods, but the threat to the public health is potentially great and is growing rapidly.

If statistics on silicosis in mines are a legitimate part of the data base of this study, the recently published data of Mancuso[7] showing increased cancers in workers in the nuclear industry should also have been incorporated. Our committee does not share the Council's pessimistic attitude toward the potential contribution to be made by clean and renewable energy sources such as solar, wind, and geothermal. Indeed, such pessimism only serves to further stifle the development of these sources which have minimal adverse health effects.

The SMS Committee on Environmental Health will not repeat the errors of the AMA Council on Scientific Affairs. A comparison between health effects of coal and nuclear generation of electricity is a complex task in view of the fact that the young nuclear industry is still establishing its "track record." If organized medicine is to form an opinion on this subject, it is important

that our position not be misinterpreted or misused by the industry.

Bearing this in mind, the Committee on Environmental Health has drafted and submitted a Clean Energy Resolution to the SMS House of Delegates which meets May 10-12 in Milwaukee. This resolution calls upon the AMA House of Delegates to reconsider its support of "Health Effects" and commission a new independent study. In our resolution we call for improvement in mine safety and application of available technology to reduce coal plant emissions to the ambient air. We call on Congress to deal effectively with uranium mine tailings and for the federal government to establish a safe method of disposition of the spent fuel rods from nuclear power plants. We call on the AMA to encourage more efficient use of our current energy and for increased support of clean and renewable energy sources.

We have limited our approach to energy generation to those aspects directly affecting the public health. Matters pertaining to economics of energy-generation are not within the realm of physician-expertise. Our resolution does not call for a moratorium on nuclear power because of the complexity and many facets of the debate on the nuclear option. We have focused on the adverse health effects of both coal and nuclear generated electricity and call for alleviation and elimination of these health effects as the legitimate responsibility of the power source.

The SMS Committee On Environmental Health does not believe the AMA's "Health Effects" is representative of the viewpoint of Wisconsin physicians. We present the Clean Energy Resolution to our membership as an opportunity for a responsible approach by organized medicine in guiding our energy future.

—Wendelin W Schaefer, MD, Sheboygan
Chairman, SMS Committee on Environmental Health

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Health Services

Editor: DOUG NELSON
Director, Health Services Division

Jail health care in Wisconsin

A report on the State Medical Society of Wisconsin's involvement in a National Jail Health Care Project

Prepared by **Timothy Corrigan** in collaboration with **Gerald W Poindexter, MD,** Chairman of the Wisconsin Jail Health Care Committee, and State Medical Society Staff

IT HAS BEEN SAID that there is nothing quite as frightening as being locked-up in a jail cell, deprived of your freedom of choice and utterly dependent upon others for your basic human needs. One of the biggest fears many inmates have upon entering a jail is: What if I get sick? Will anyone be there to help me?

The American Medical Association in 1972 upon request from the American Bar Association conducted a national survey of correctional institutions which indicated that in too many instances there wasn't adequate medical care available for inmates in the United States jails. At the time, the availability of medical care and health services for inmates in most of the 4,000 county and city jails in the US could be described in one word: appalling!

Meanwhile, hundreds of lawsuits were being filed and many were being won by inmates at the state and federal court levels where it was judged that denial of adequate medical care in jails constituted "cruel and unusual punishment."

In response to this glaring problem, the AMA and the US Justice Department, with funding from the Law Enforcement Assistance Administration (LEAA), initiated a program to improve the levels of medical care and health services in jails.

The AMA designed the program to involve local physicians and state medical societies whereby each could make its own commitment to improving the level of health and medical care in the nation's jails.

The first step was to select six states and 30 jails to serve as pilot projects, which would be surveyed for needs, problems, and adequacy of health care provided. The results of this pilot project would then be used to set up standards for all US jails.

The State Medical Society of Wisconsin was among those six state medical societies selected to participate in the pilot project. In Wisconsin during 1976, nearly 3,200 inmates were held in state prisons, but 74,000 were held in county jails. Of these 5,800 were women and 15,000 were juveniles. Many of these individuals had never been convicted of any offense. They were awaiting trial and hadn't the money for bail. Many others, up to 40 percent, were serving short terms for minor offenses such as traffic violations.

Other states chosen from a field of 22 that expressed an interest in being considered for the pilot program included Georgia, Indiana, Maryland, Michigan, and Washington. Each of the six

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Mr Corrigan was a journalism intern with Zigman-Joseph-Skeen, public relations counselors, at the time of the writing. Reprint requests to: State Medical Society of Wisconsin, Jail Health Care Committee, PO Box 1109, Madison, Wis 53701. Copyright 1979 by the State Medical Society of Wisconsin.

state medical societies chosen by the AMA received an initial operating grant of $25,000 and was to be involved in the testing and development of standards of health care in jails that could be used in a national accreditation program for health and medical care in jails. The State Medical Society of Wisconsin has received additional operating grants totaling $45,000 for the second and third years of the program.

Why was Wisconsin selected to take part in this new program to upgrade medical care in jails? The AMA said Wisconsin was selected because of the variety of correctional institutions in the state; the possibility of long-term results, and the strong community support for such a program.

To oversee the project in Wisconsin, the State Medical Society created a Jail Health Committee. Chaired by Gerald W Poindexter, MD, Milwaukee, the Committee includes representatives from health care, community, church, legal and governmental organizations.

In 1976 the Jail Health Care Project in Wisconsin began working with three county jails: Adams, Eau Claire, and Milwaukee, representing small, medium, and large jails in rural and urban areas around the state. County sheriffs, jail personnel, and physicians joined together in a total voluntary effort.

These jails were then surveyed as to their existing health services. Through the development of an "Inmate-Patient Profile," the health status of individual inmates was tested. This profile consisted of three parts: 1) a health history and laboratory tests, 2) a physical examination, and 3) an inmate assessment of current health services in the jail. Local physicians, nurses, hospital laboratory technicians, and hospital and county health department labs volunteered their time and services in all three jails for the inmate-patient profiles and a followup assessment one year later.

The Wisconsin Jail Health Care Committee then sent the results to the AMA which, in turn, issued a report of the total findings of all six states. The report cited many obvious inadequacies in health services in jails such as poor rapport between county sheriffs and the medical community (neither understanding the other's problems); unnecessary expenses in transporting inmates to hospitals and doctors' offices; and lack of a system and/or guidelines for health screening of inmates in the jails.

Prior to initiation of the Jail Health Care Project in Wisconsin, health care services in most of the smaller jails were provided in hospital emergency rooms or doctors' offices. In many instances complaints of the inmates were not serious enough to warrant treatment at either of these locations, resulting in an unnecessary expense for the community. Some doctors were reluctant to have handcuffed inmates in their reception areas along with their other patients. On the other hand, many sheriffs and jail personnel did not know how to approach the doctor in asking for help to see or treat an inmate. Doctors shunned treating inmates anywhere because of a lack of standards or guidelines as to the responsibility of the doctor, the sheriff, the inmate, and the community. Only in rare instances did any medical personnel actually go into the jails to screen inmates, either to treat them or to refer them to doctors. In a few counties the county health nurse was on-call, but the nurse did not conduct sick-call on a regularly scheduled basis.

In 1977 an accreditation program was launched in the six pilot states. The program requires compliance with minimum medical and health standards before a jail can receive AMA accreditation. These Standards have been tested in the pilot jails and amended according to input received from correctional personnel and physicians. In fact the AMA recently released the 20th draft of these Standards for jail accreditation.

Of the 42 standards established by the American Medical Association, there are a basic 10 that must be met by a jail wishing to be accredited by the Program. Briefly the Standards require that a physician be responsible for the operation of the jail's health services such as written standard operating procedures, covering health screening of each inmate at the time of booking, and that jails provide 24-hour emergency medical and dental services, adequate access to sick-call held by medical personnel, nonemergency care, administration of prescribed drugs, chronic and convalescent care, and detoxification from alcohol and drugs.

"Accreditation is a formal method for organized medicine to recognize that a particular jail has met nationally recognized minimum standards. It acts as an incentive for jails to improve their health care delivery systems and is a vehicle to ward off and defend against litigation. It also serves as a way to elicit community support for improvements that jail personnel are trying to make in their jails."

One or two-year accreditations from the SMS-AMA Jail Health Program are awarded to those jails meeting the 10 required standards plus a large percentage of the remaining 32 standards. Accreditation is a formal method for organized medicine to recognize that a particular jail has met nationally recognized minimum standards. It acts as an incentive for jails to improve their health care delivery systems and is a vehicle to ward off and defend against litigation. It also serves as a way to elicit community support for improvements that jail personnel are trying to make in their jails.

Wisconsin Jail Health Care Committee:

- Six physician members of the State Medical Society of Wisconsin:
  - Gerald W Poindexter, MD, Milwaukee Chairman
  - George E Batayias, MD, Milwaukee
  - Richard W Edwards, MD, Richland Center
  - Paul R Glunz, MD, Beaver Dam
  - Harold J Kief, MD, Rhinelander
  - John H Renner, MD, Madison
- Representatives of fourteen organizations:
  - Wisconsin Dental Association
  - League of Women Voters
  - Wisconsin County Boards Association
  - Wisconsin Council of Churches
  - Wisconsin Department of Health and Social Services, Division of Corrections
  - Wisconsin Chiefs of Police Association
  - Wisconsin Sheriffs and Deputy Sheriffs Association
  - State Bar of Wisconsin
  - Wisconsin Division of Health, DHSS
  - University of Wisconsin Center for Health Sciences
  - Medical College of Wisconsin
  - Wisconsin Council of Criminal Justice
  - Wisconsin Division, Health Policy and Planning
  - Wisconsin Hospital Association
- One Public Member (Ex-offender)

State Medical Society Staff:

Parks Reinhardt, Madison
General Administration

John C LaBissoniere, Madison
Health Services Division

Howard O Brower, Madison (now retired)
Health Services Division

In mid-1977 the six pilot states attempted to accredit some of the participating jails in the project. The Eau Claire and Milwaukee county jails were among the first in the nation to become accredited by the Jail Health Program in 1977. Later, in 1978, the Adams and Dane county jails were awarded certificates of accreditation for their compliance in meeting the high standards of the project.

Since then, the Wisconsin Jail Health Care Project has added 12 new participating county jails including: Columbia, Dodge, Dunn, Green, Pierce, Racine, Rock, St Croix, Walworth, Washington, Winnebago, and Waukesha. Four of these jails presently are applying for accreditation.

The success of the Jail Health Care Project in Wisconsin was further demonstrated in April 1978 when the Eau Claire County Jail was one of the first four jails in the country to receive a two-year reaccreditation from the program for its health and medical care services.

Joseph Rowan, director of the AMA's Program to Improve Medical Care and Health Services in Correctional Institutions, recently stated that this program could eventually mean fewer tax dollars spent on jail medical care. "This may be accomplished through greater use of a community's existing health services such as the county health department, Unified Services Board, and voluntary health-oriented organizations for health education."

Rowan expressed great satisfaction with the work of the State Medical Society in its efforts to institute the Jail Health Care Project in Wisconsin.

"The Society's Jail Health Care Committee and its staff: Howard Brower, John LaBissoniere, and Parks Reinhardt, have done a particularly fine job in two important areas: developing a good working relationship with the state's sheriffs and county jail staffs, and in increasing the involvement of mental health agencies in the Jail Health Care Project," Rowan commented.

Parks Reinhardt of the SMS Jail Health Care Project staff is encouraged by the results of the Project Program in Wisconsin. "Not only does the Jail Health Care Project help inmates in regard to their individual health care but also jails have found it to be cost-effective in comparison to the manner in which medical services were previously obtained."

"As an example, in one of the larger jails in Wisconsin, the sheriff for one week hired a nurse who visited the jail and screened inmates. This saved the community $1,000 in doctors' fees,

transportation to medical care facilities, and armed guard expenses. In another instance, a nurse visited the jail once a day to change dressings and to check the condition of a serious wound. She taught the EMT-trained jailer how to change the dressings in the evening, thus saving $275 per day over the cost of providing 24-hour guards and hospital charges for inpatient treatment."

"The community benefits, too," she added. "Health screening procedures done in the jails have cut down on the incidence of undetected and untreated communicable diseases which would make their way into the community upon the inmate's release."

Some participating Wisconsin sheriffs have noticed a marked reduction of stress on the part of inmates and jailers alike because of the Project.

Eau Claire Sheriff Larry Jacobson said the Project has created less tension among jail inmates since "they know their situation isn't hopeless and that they can get medical attention when they need it."

Thus, the Jail Health Care Project in Wisconsin has created a "forum" for sheriffs, doctors, inmates, and the community to develop a system of care that takes into consideration each one's "hang-ups" about the others. Learning to know and understand each other's responsibilities has been a key factor in the Project's success.

Rowan points out that the Project has proven to be a particularly rewarding experience for physicians and other health care providers because it offers an opportunity that many would not find in their normal practices.

"Most physicians and other health care providers who have become involved in developing jail health care systems have found working with jail staff and inmates challenging and uniquely different," Rowan said.

What does the future hold for the Jail Health Care Project nationally and in Wisconsin? The initial LEAA grant to the AMA runs out in April 1979, making the future of the program uncertain at best. Both the AMA and the State Medical Society of Wisconsin have expressed a genuine interest in making the program a permanent one.

Ideally, the AMA and State Medical Society would like to see the program become self-sustaining. In such a program, a jail would pay a fee to become accredited as all hospitals and schools do. Rowan sees this as a "purchase of a service." Both organizations see this trend to a self-sustaining program as a slow and gradual process. In the meantime, the AMA is seeking funding from private foundations as well as exploring the possibility of future LEAA funding for the program.

The future of the Jail Health Care Project also has a great deal to do with the success jails have in maintaining their accreditation status, and in getting more county jails to participate in the program. If the accreditation program for jails is to become truly national in scope, continued support of the program must be given. It's up to the community, legal, law enforcement, and medical organizations to provide this much needed support.

"Society has a responsibility for the people it incarcerates," says SMS Jail Health Care Committee Chairman Gerald Poindexter, MD, Milwaukee. "Jail inmates are not people whom you can put out of sight, out of mind. They reflect the outside community from which they come, and they will influence it medically and attitudinally, when they return to it." ■

16 COUNTY JAILS ARE PARTICIPATING IN THE WISCONSIN JAIL HEALTH CARE PROJECT:

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Adams	**Dunn**	**Rock**	**Winnebago**
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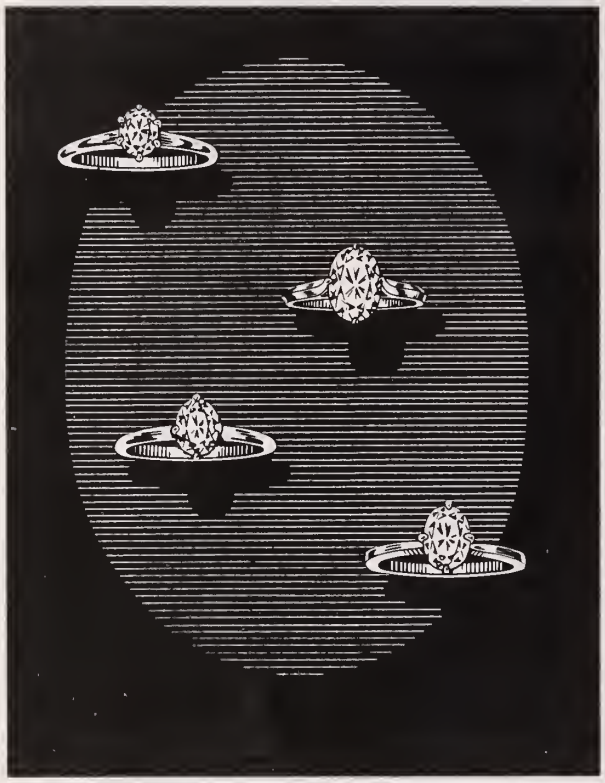
Is your county jail one of them? If not, would you like to recommend that your county jail participate? To do so, please contact the State Medical Society of Wisconsin, Attention Parks Reinhardt, PO Box 1109, Madison, Wis 53701; or phone toll-free 1-800-362-9080.



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*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)	
Bottles of 60	NDC 0009-0733-01
Bottles of 500	NDC 0009-0733-02
Motrin Tablets, 400 mg (orange)	
Bottles of 60	NDC 0009-0750-01
Bottles of 500	NDC 0009-0750-02
Unit-dose package of 100	NDC 0009-0750-06
Unit of Use bottles of 120	NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

NIM-3

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

MSD MERCK SHARP & DOHME

ALDOMET®
(METHYLDOPA|MSD)

TABLETS: 500 mg, 250 mg, and 125 mg

State Medical Society of Wisconsin

1979 ANNUAL MEETING

Thursday-Friday-Saturday

May 10-11-12/Milwaukee

Milwaukee Exposition & Convention Center & Arena (MECCA)

Headquarters Hotel: The Marc Plaza (MP)

TIMETABLE

THURSDAY MORNING/May 10

8:00 CPR Training (East Outer Corridor, 2nd fl/MECCA)

8:00 Breakfast and Board Meeting—Wisconsin Academy of Family Physicians (Van Gogh/MP)

10:00 Board Meeting and Luncheon—Wisconsin Chapter, American College of Surgeons (DaVinci/MP)

10:30 Section Delegates Caucus (Rembrandt/MP)

THURSDAY AFTERNOON/May 10

1:00 Registration HOUSE OF DELEGATES (West Octagon/MECCA)

2:00 1st Session, HOUSE OF DELEGATES (West Octagon/MECCA)

THURSDAY EVENING/May 10

6:00 WOMEN IN MEDICINE Program (MP) (Room to be posted at MP)

6:00 Social Hour (Cash Bar) (for those attending WOMEN IN MEDICINE Program)

7:00 Dinner (for those attending WOMEN IN MEDICINE Program which follows dinner)

7:30 Open Hearing, AMA Delegates (Chagall/MP)

7:30 Reference Committee Meeting (DaVinci, Picasso, Rembrandt, Van Gogh/MP)

FRIDAY MORNING/May 11

7:15 MEDICINE & RELIGION Breakfast: Catholic Physicians Guild (Regency/MP)

8:00 CPR Training (East Outer Corridor, 2nd fl/MECCA)

8:30-10:00 LEGISLATION Panel (W-10/MECCA)

9:00-10:20 OBESITY Panel (E-2/MECCA)

9:00-10:30 AREAWIDE MCE STUDIES Panel: Tools for Assessing Trends and Quality Care on a Regional Level (E-10/MECCA)

9:00-12:00 PSYCHIATRY Program (E-4 & E-5/MECCA)

9:00-12:00 RESIDENT PHYSICIANS SECTION Business Program (E-9/MECCA)

10:00-12:00 PLASTIC SURGERY Program (E-3/MECCA)

10:00-11:00 PHYSICIANS AND HEALTH PLANNING Panel: Making Up for Lost Time (W-10/MECCA)

10:30 WISCONSIN SOCIETY OF RADIATION ONCOLOGY Business Meeting (W-7/MECCA)

10:40-12:00 INTERNATIONAL HEALTH Panel (E-2/MECCA)

11:00 Wisconsin Review Foundation/Wis-PRO Board Meeting and Luncheon (Van Gogh/MP)

FRIDAY AFTERNOON/May 11

12:15-3:30 PLASTIC SURGERY Luncheon and Program (E-3/MECCA)

12:15-1:30 RADIATION ONCOLOGY Luncheon and Program (W-10/MECCA)

12:15-1:45 WISPAC Luncheon (West Hall, 1st fl/MECCA)

1:45-4:00 RESIDENT PHYSICIANS SECTION Program (E-9/MECCA)

1:45-4:45 PROSTATIC CARCINOMA Panel (E-2/MECCA)

2:00-5:00 PSYCHIATRY Program (West Hall, 1st fl/MECCA)

2:00-3:30 PUBLIC HEALTH AND PREVENTIVE MEDICINE Program and Business Meeting: Section on Public Health and Preventive Medicine (W-7/MECCA)

2:00 Wisconsin Review Foundation/Wis-PRO Annual Meeting (English Room/MP)

continued on next page

ANNUAL MEETING TIMETABLE continued

FRIDAY AFTERNOON/May 11 . . . continued

3:00 Registration HOUSE OF DELEGATES (West Octagon/MECCA)

3:30-4:40 WISCONSIN SOCIETY OF PLASTIC SURGEONS Annual Business Meeting (E-3/MECCA)

4:00 2nd Session HOUSE OF DELEGATES (West Octagon/MECCA)

4:30 WISCONSIN NUCLEAR MEDICINE GROUP Program (Dali Room/MP)

FRIDAY EVENING/May/11

6:00 WISCONSIN SOCIETY OF PLASTIC SURGEONS Social Hour and Dinner (Brynwood Country Club)

6:30 PRESIDENTS' RECEPTION (Crystal Ballroom Foyer/MP)

7:30 PRESIDENTS' DINNER (Crystal Ballroom/MP)

SATURDAY MORNING/May 12

7:30 Registration, House of Delegates (West Octagon/MECCA)

8:00 3rd Session, House of Delegates (West Octagon/MECCA)

8:00 SECTION ON OPHTHALMOLOGY Board Meeting (E-8/MECCA)

8:30-11:45 SURGERY Program (Mount Sinai Medical Center)

9:00-10:20 IMMUNOLOGY Panel (E-5/MECCA)

9:00-11:55 LUMBAR DISC DISEASES Panel (E-2/MECCA)

9:00-12:00 OPHTHALMOLOGY Program (E-3/MECCA)

9:00-12:00 ORTHOPAEDICS Program (West Hall, 1st fl/MECCA)

9:00-12:00 OTOLARYNGOLOGY Program (E-10/MECCA)

9:00-11:00 RADIOLOGY Program (W-10 MECCA)

9:30-12:00 PATHOLOGY Program (E-4/MECCA)

10:00-12:00 THE IMPAIRED PHYSICIAN Panel (W-9/MECCA)

10:30 SECTION ON ANESTHESIOLOGY Board Meeting (W-7/MECCA)

10:30 COUNCIL Meeting (Van Gogh/MP)

SATURDAY MORNING/May 12 . . . continued

11:00-12:00 WISCONSIN RADIOLOGICAL SOCIETY Business Meeting (W-10/MECCA)

11:30 AESCULAPIAN SOCIETY Meeting (Westminster/MP)

11:45 SURGERY Luncheon (Mount Sinai Hospital)

12:00 COUNCIL and PAST PRESIDENTS Luncheon (English Room/MP)

SATURDAY AFTERNOON/May 12

12:15-4:30 ALLERGY AND CLINICAL IMMUNOLOGY Luncheon, Program, and Business Meeting: Wisconsin Allergy Society (W-5/MECCA)

12:15-4:30 ANESTHESIOLOGY Luncheon, Business Meeting: Section on Anesthesiology, and Program (W-2/MECCA)

12:15-4:30 DERMATOLOGY Luncheon and Program (W-3/MECCA)

12:15-3:30 EMERGENCY MEDICINE Luncheon, Program, and Business Meeting: Wisconsin Chapter, American College of Emergency Physicians (E-14/MECCA)

12:15-4:15 INTERNAL MEDICINE Luncheon and Program (E-5/MECCA)

12:15-4:30 NEUROLOGY Luncheon, Program, and Business Meeting: Wisconsin Neurological Society (E-7/MECCA)

12:15 OPHTHALMOLOGY Luncheon and Business Meeting: Section on Ophthalmology (E-3/MECCA)

12:15-4:30 ORTHOPAEDICS Luncheon, Program, and Business Meeting: Wisconsin Orthopaedic Society (West Hall, 1st fl/MECCA)

12:15-3:30 OTOLARYNGOLOGY Luncheon and Program (E-10/MECCA)

12:15-5:00 PATHOLOGY Luncheon, Business Meeting: Section on Pathology, and Program (E-4/MECCA)

12:15-4:30 PHYSICAL MEDICINE & REHABILITATION Luncheon and Program (E-12/MECCA)

1:30-5:00 SURGERY Program and Business Meeting: Wisconsin Surgical Society (E-2/MECCA)

continued on next page

ANNUAL MEETING TIMETABLE continued

SATURDAY EVENING/May 12

6:30 WISCONSIN SOCIETY OF INTERNAL MEDICINE Social Hour and Dinner (Milwaukee Athletic Club)

WISCONSIN SURGICAL SOCIETY Evening Dinner (Milwaukee Athletic Club)

6:30 WISCONSIN ORTHOPAEDIC SOCIETY Dinner (University Club) ■

PRESIDENTS' RECEPTION AND DINNER

Friday, May 11/Marc Plaza

6:30 Reception (Foyer, 5th floor)

7:30 Dinner (Crystal Ballroom, 5th floor)

The Wisconsin Singers
Entertainment: This year's show offers a complete theatrical presentation, with new show outfits, many costumes, and new and unique choreography. Special musical numbers include songs made famous by Duke Ellington, Barry Manilow, The Carpenters, Captain and Tennille, and audience favorites such as "The Collegiate Medley" and "Television Theme Songs."

You'll marvel at the professional talent shown by this group of 24 singers/dancers, backed by a three-piece Combo. All are students in various disciplines on the UW-Madison Campus.

Tickets: $20.00

WISPAC LUNCHEON

West Hall, 1st floor, MECCA
Friday, May 11—12:15 pm

Program details to be announced

Tickets: $11.00

MEDICINE & RELIGION BREAKFAST

Regency Room, 5th floor, Marc Plaza
Friday, May 11—7:15 am

"I Envy Doctors!"

Rabbi Manfred E Swarsensky, PhD
Professor of Religion, Edgewood College, Madison

Tickets: $5.00

Special Programs

THURSDAY/MAY 10

CPR Training, 8:00 am, East outer corridor, 2nd fl/MECCA

Women in Medicine, 6:00 pm, MP (Room to be posted at MP)

Program starts with Social Hour (cash bar) followed by Dinner at 7:00 pm. Theme: *Myths, Ms, or Doctor*

Carol Nadelson, MD, Boston, MA; Associate Professor of Psychiatry, Beth Israel Hospital

Patricia J Stuff, MD, Bonduel: AMA Delegate, Past Speaker, SMS House of Delegates

Panel: Doctors Lucille Glicklich, Carol Nadelson, Patricia Stuff

Lucille Glicklich, MD, Milwaukee: Pediatrician specializing in child psychiatry, Milwaukee Children's Hospital

Physicians are encouraged to bring House Staff and/or Medical Students as guests. Dinner tickets at $10 each may be obtained from:

Lucille Glicklich, MD
Milwaukee Children's Hospital
1700 West Wisconsin Ave
Milwaukee, WI 53201 (ph 414/931-4079)

FRIDAY/MAY 11

Medicine and Religion Breakfast, 7:15 am, Regency/MP, sponsored by Catholic Physicians Guild

CPR Training, 8:00 am, East outer corridor, 2nd fl/MECCA

Legislation Panel, 8:30-10:00 am, W-10/MECCA

Presented by State Medical Society's Physicians Alliance Division; *Brian Jensen,* Director

Areawide MCE Studies Panel: Tools for Assessing Trends and Quality of Medical Care on a Regional Level, 9:00-10:30 am, E-10/MECCA

Presented by Wisconsin Professional Review Organization; *Donald McIntyre,* Director

Differing viewpoints on (1) Management regarding cholecystectomy, and (2) Management and mortality associated with acute myocardial infarction.

Obesity Panel, 9:00-10:20 am, E-2/MECCA
Moderator: *Ronald K Kalkhoff, MD,* Milwaukee: Professor of Medicine; Chief, Section of Endocrinology & Metabolism, Medical College of Wisconsin

continued on next page

ANNUAL MEETING SPECIAL PROGRAMS continued

FRIDAY/May 11 . . . continued

Physicians and Health Planning Panel: Making Up for Lost Time, 10:00-11:30 am, W-10/MECCA

Moderator: *Marvin G Parker, MD,* Racine; Chairman, State Medical Society's Health Planning Commission

The panel will be composed of physicians, SMS staff, and State Division of Health staff who will discuss the rationale for health planning, the planning agencies, and the manner in which physicians can influence health planning policies.

International Health Panel, 10:40-12:00 noon, E-2/MECCA

Moderator: *Richard W Biek, MD,* MPH, Veterans Home, King

Subjects: The World Medical Association and International Health; International Health and American Health

WISPAC Luncheon, 12:15-1:45 pm, West Hall, 1st fl/MECCA

Program to be announced by separate mailing to SMS membership.

Prostatic Carcinoma Panel, 1:45-4:45 pm, E-2/MECCA

Moderator: *Robert Edland, MD,* LaCrosse; Chairman, Department of Radiation Oncology, Gundersen Clinic Ltd

Resident Physicians Section, 9:00 am-4:00 pm, E-9/MECCA

Chairman and Vice Chairman's reports; report of Delegates; discussion of resolutions; AMA Delegates report; election speeches; voting (morning session)

Cost Awareness in Graduate Medical Education; panel discussion (afternoon session)

Wisconsin Nuclear Medicine Group, 4:30 pm, Dali Room/MP

SATURDAY/MAY 12

Immunology Panel, 9:00-10:20 am, E-5/MECCA

Moderator: *William W Busse, MD,* Madison; Head, Department of Allergy and Clinical Immunology, University of Wisconsin Medical School

Theme: *Practical Application and New Things in Immunology*

Controversies in the Management of 'Lumbar Disc Diseases', 9:00-12:00 noon, E-2/MECCA

Moderator: *Sridhar V Vasudevan, MD,* Milwaukee: Assistant Professor, Department of Physical Medicine & Rehabilitation, Medical College of Wisconsin; Associate Medical Director, Curative Rehabilitation Center

continued in next column

SATURDAY/May 12 . . . continued

The Impaired Physician Panel, 10:00-12:00 noon, W-9/MECCA

Theme: *Your Impaired Colleague IS Your Business*

Introduction: *Gerald C Kempthorne, MD,* Spring Green: Chairman, Commission on Mediation and Professional Ethics, State Medical Society of Wisconsin

Moderator: *Harry F Weisberg, MD,* Milwaukee: Member, Commission on Mediation and Professional Ethics, State Medical Society of Wisconsin

Topics: (1) Problems with alcohol and other drugs seen from the inside—and what has to be done, (2) The emotionally troubled physician, (3) The senile physician—a delicate issue, (4) Impaired physicians' legal relationships with hospital staffs and the Medical Examining Board, (5) Preventing impairment in medical students and housestaff, and (6) Open discussion.

SCIENTIFIC PROGRAM PLANNERS

Commission on Continuing Medical Education

Warren J Holtey, MD, *Chairman,* Marshfield

George A Berglund, MD, *Vice-chairman,* Milwaukee

Joseph C Darin, MD, Milwaukee

Martin Z Fruchtman, MD, Waukesha

Bradley G Garber, MD, Osseo

William E Hein, MD, Green Bay

James T Houlihan, MD, Woodruff

John L Raschbacher, MD, Waukesha

Leonard H Wurman, MD, Wausau

Sigurd E Sivertson, MD (UW)

Willard Duff, PhD, (MCW)

Elizabeth A Steffen, MD, Council Liaison to Commission, Racine

SCIENTIFIC PROGRAM COMMITTEE

Joseph C Darin, MD, Milwaukee, *Chairman*

Leonard H Wurman, MD, Wausau, *Cochairman*

CHAIRMAN, SCIENTIFIC EXHIBITS

William E Hein, MD, Green Bay

STAFF

William G Wendle *Scientific Affairs Coordinator*

Arlene K Meyer *Administrative Assistant*
CONTINUING MEDICAL EDUCATION

Schedule of Scientific Programs by Specialty

(in alphabetical order)

SATURDAY/MAY 12

Allergy & Clinical Immunology
W-5/MECCA

Program accredited through Wisconsin Allergy Society for 2 hours of Category 1 credit of PRA-AMA

Moderator: *Robert Kriz, MD,* Madison

12:15 Luncheon: *Controversial Aspects of Asthma Pharmacotherapy*

2:00 Scientific Program: *Absorption Characteristics of Theophylline and Rationale for Sustained Release/The Role of the Basophil in the Immediate and Delayed Hypersensitivity Response/New Standards in Screening Spirometry*

3:30 Recess to view exhibits

4:00 Business Meeting: Wisconsin Allergy Society

4:30 Adjournment

Anesthesiology
W-2/MECCA

Program accredited through the AMA for 3 hours Category 1 credit of PRA-AMA.

Moderator: *George L Bush, MD,* Madison

12:15 Luncheon

1:00 Scientific Program: *Are There Health Hazards Associated with Operating Room Employment?*
Business Meeting: Section on Anesthesiology
Recess to view exhibits

2:30 *Practical Aspects of Reducing Operating Room Pollution/Malignant Hyperthermia: Endemic in Wisconsin?*

4:30 Adjournment

Dermatology
W-3/MECCA

Program accredited through Wisconsin Dermatological Society for 3 1/2 hours Category 1 credit of PRA-AMA.

Moderator: *Nyles R Eskritt, MD,* Stevens Point; President, Wisconsin Dermatological Society

12:15 Luncheon

1:00 Scientific Program: *The Dilemma of Herpes Simplex/Porphyria and Recent Hexachlorobenzene Porphyria, in Turkey/Zinc Deficiency Dermatoses/Erythema Multiforme Clinical*

(*continued in next column*)

and Immunofluorescent Aspects/Versatility in Skin Surgery/Puva Treatment/Extramammary Paget's Disease

4:30 Adjournment

Emergency Medicine
E-14/MECCA

Program cosponsored by American College of Emergency Physicians. Approved for 2 hours Category 1 credit; acceptable for 2 hours elective credit of American Academy of Family Physicians; qualifies for 2 hours Category 1 credit of PRA-AMA.

Moderator: *Gordon L Johnson, MD,* La-Crosse; Gundersen Clinic Ltd

Informal discussion on *Need for and Requirements of the Advanced Cardiac Life Support Course*

12:15 Luncheon

1:00 Scientific Program: *Treatment of Acute Respiratory Failure and Asthma in the Emergency Department/Brady-Arrhythmias and Tachyarrhythmias: A Mechanistic Approach to Diagnosis and Emergency Treatment*

3:00 Business Meeting: Wisconsin Chapter, American College of Emergency Physicians

3:30 Adjournment

Internal Medicine
E-5/MECCA

Program, which has been approved for 3 1/2 hours of Category 1 credit by American College of Physicians, is being cosponsored by the State Medical Society of Wisconsin

Moderator: *Dean A Emanuel, MD,* Marshfield

12:15 Luncheon

12:45 Scientific Program: *Coronary Heart Disease—An Overview of the Risk Factors / Atherogenesis / Lipoproteins As Risk Factors in Coronary Heart Disease/Coronary Artery Surgery in Patients with Coronary Heart Disease/Panel discussion*

4:15 Adjournment

Neurology
E-7/MECCA

Program is accredited through the Wisconsin Neurological Society for 2 1/2 hours Category 1 credit of PRA-AMA.

Moderator: *Michael P McQuillen, MD,* Milwaukee: Medical College of Wisconsin

12:15 Luncheon: *Football and Migraine*

1:30 Scientific Program: *Symposium on Cerebral Death*

(*continued on next page*)

SCHEDULE OF SCIENTIFIC PROGRAMS continued

SATURDAY/May 12 . . . continued

2:30 Recess to view exhibits

2:45 Scientific Program continued

4:00 Business Meeting: Wisconsin Neurological Society

4:30 Adjournment

Ophthalmology
E-3/MECCA

Program accredited through the Section on Ophthalmology for 3 hours of Category 1 credit of PRA-AMA.

Moderator: *Richard O Schultz, MD,* Milwaukee: Medical College of Wisconsin

9:00 Scientific Program: *Symposium—Cryosurgery in the Treatment of External Ocular Diseases and Ocular Neoplasms*

12:15 Luncheon
Business Meeting: Section on Ophthalmology

2:00 Adjournment

Orthopaedics
West Hall, 1st fl/MECCA

Program accredited through Wisconsin Orthopaedic Society for 4 hours Category 1 credit of PRA-AMA.

Moderator: *Paul K Odland, MD,* Janesville; President, Wisconsin Orthopaedic Society

9:00 Registration

9:30 Scientific Program: *The Use of Operative Arthroscopy in the Treatment of Osteochondritis Dissecans/Patellofemoral Instability/Unicompartmental Knee Replacement*

10:30 Recess to view exhibits

10:45 *Experiences with Revascularization and Re-implantation in Amputated and Near Amputated Digits of the Hand/Club Feet/Proximal Humeral Fractures—Residual Deformity Compared with Long Term Function*

12:15 Luncheon

1:30 *Normal and Abnormal Growth of the Growth Plate/Significant Collagen Fibers in Arthritic Joint Fluid by Biochemical Means*

3:00 Recess to view exhibits

3:20 *Results of Total Knee Replacements—USI Gustivo Type/Back Pain in Runners*

4:00 Business Meeting: Wisconsin Orthopaedic Society

4:30 Adjournment

(continued in next column)

Otolaryngology
E-10/MECCA

9:00 Dry Clinic

Program accredited through Wisconsin Otolaryngological Society for 4 hours Category 1 credit of PRA-AMA.

Moderator: *Jerry E Friedman, MD,* Milwaukee; President, Wisconsin Otolaryngological Society

9:30 Scientific Program: *Presentation of Otorhinolaryngological Problems*

12:15 Luncheon

1:30 Scientific Program: Presentation of papers by members/*Evoked Response Audiometry Principles, and Practical Application for the Practicing Otolaryngologist*

3:30 Adjournment

Pathology
E-4/MECCA

9:30 Registration

Program accredited through Wisconsin Society of Pathologists for 5 hours Category 1 credit of PRA-AMA.

Photography for Pathologists

Moderator: *Richard Komorowski, MD,* Milwaukee

10:00 Scientific Program: *Gross Specimen Photography/Photomicrography*

12:15 Luncheon

1:15 Business Meeting: Section on Pathology

2:00 *Seminar: Gynecologic Pathology*

5:00 Adjournment

Physical Medicine & Rehabilitation
E-12/MECCA

12:15 Luncheon

Moderator: *Sridhar V Vasudevan, MD,* Milwaukee

1:00 Scientific Program: *The Tension Myositis Syndrome—Diagnosis and Management/An Outpatient Chronic Pain Management Program/An Inpatient Chronic Pain Management Program/Nerve Block Procedures in Managing Pain/*Panel Discussion

4:30 Adjournment

(continued on next page)

SCHEDULE OF SCIENTIFIC PROGRAMS continued

SATURDAY/MAY 12 . . . continued

Radiology

W-10/MECCA

Moderator: *Thomas J Imray, MD,* Milwaukee

9:00 Scientific Program: *Interventional Radiology*/Discussion

10:00 Recess to view exhibits

10:15 *Percutaneous Transhepatic Cholangiography and Its Therapeutic Counterpart*

11:00 Business Meeting: Wisconsin Radiological Society

12:00 Adjournment

Surgery

Morning Session: Mount Sinai Medical Center

Program accredited through Wisconsin Surgical Society for 6 hours of Category 1 credit of PRA-AMA.

8:30 Registration

9:00 Scientific Program: *Preservation of Human Myocardial Contractility During Anoxic Arrest*/Discussion/*Mitral Valve Replacement with Beating, Non-Working Heart*/Discussion/*Extended Femoral-Popliteal Bypass Grafting* / Discussion / *Postsurgical Stroke in Cardiac and Peripheral Vascular Disease*/Discussion

10:20 Coffee Break

10:45 *Prediction of Graft Rejection by Pretransplant Parameters Including Transfusion History* / Discussion / *Microvascular Surgery* / Discussion/ *Experience with Gastric Bypass*/ Discussion

11:45 Luncheon (Mount Sinai Hospital)

Afternoon Session: E-2/MECCA

Moderator: *Walton D Thomas, MD,* Milwaukee; President, Wisconsin Surgical Society

1:30 Scientific Program: *CT Scanning and Ultrasound in Pancreatic Disease/ Diagnostic and Therapeutic Roles of ERCP in Pancreatic Disease/Surgical Management of Acute and Chronic Pancreatic Disease*/Panel Discussion

3:15 Recess to view exhibits

3:45 *The EEA Stapler for Colonic Anastomoses*/Discussion/*Starch Peritonitis Revisited* / Discussion / *Incidental Appendectomy in the Elderly?—No*/ Discussion

4:30 Business Meeting: Wisconsin Surgical Society

5:00 Adjournment

HOUSE OF DELEGATES

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session on Thursday afternoon, starting at 2:00. Reference committees will meet Thursday evening at 7:30, with reports to be made at the Friday afternoon session, starting at 4:00. The third session, with election of officers, and installation of the President, will be held on Saturday morning, starting at 8:00. Registration of delegates and alternates precedes the first and second sessions by one hour, the third session by one-half hour. Society members are urged to participate in the discussions on reports and resolutions in the open hearings of the reference committees. A summary of the resolutions appeared in the March issue of *WMJ*. Nominees for Society offices also were announced in the March issue, with a biographical sketch of each. Delegates and alternates, officers, councilors, and commission/committee chairmen have received the House of Delegates HANDBOOK containing reports and resolutions to be submitted to the House. These were discussed at the District Caucuses held during March and April, preceding the Annual Meeting.

Schedule

Thursday, May 10

10:30 Section Delegates Caucus (Rembrandt-MP)
1:00 Registration, House of Delegates (West Octagon/MECCA)
2:00 1st Session, House of Delegates (West Octagon/MECCA)
7:30 Open Hearing, AMA Delegates (Chagall-MP)
7:30 Reference Committee Meetings (DaVinci, Picasso, Rembrandt, Van Gogh-MP)

Friday, May 11

3:00 Registration, House of Delegates (West Octagon/MECCA)
4:00 2nd Session, House of Delegates (West Octagon/MECCA)

Saturday, May 12

7:30 Registration, House of Delegates (West Octagon/MECCA)
8:00 3rd Session, House of Delegates (West Octagon/MECCA)

SMS HEALTH PLANNING SLIDE PRESENTATION

Friday, May 11 & Saturday, May 12
Room W-11/MECCA

SCIENTIFIC EXHIBITS

Sponsoring institution(s) followed by title of exhibit(s)

William E Hein, MD, Green Bay
Chairman, Scientific Exhibits

Columbia Hospital, Milwaukee
Industrial Occupational Therapy (On Site Job Assessment)
Transoral Microsurgery with the CO_2 Laser

Milwaukee Children's Hospital, Milwaukee
(Audiology Department)
Simulation of Sensorineural and Conductive Hearing Losses
(Cardiac Center)
Pediatric Nuclear Cardiology
(Cleft Palate Center)
Gross and Microscopic Anatomy of Palate and Osteotomy Sites
(Dept Nuclear Medicine)
Nuclear Bone Imaging in Benign Pediatric Disorders
(Radiology Department)
Anatomy of CNS Diversionary Shunts in Children
Artifacts in Pediatric Radiology
Genitourinary Trauma in Children

Medical College of Wisconsin, Milwaukee
Ambulatory Pain Strategies (Dept Physical Medicine & Rehabilitation; Curative Workshop of Milwaukee)
Cancer of the Prostate (Dept Urology, Wisconsin Society of Radiation Oncologists)
Microsurgery in the Tubal Repair of the Infertile Female (Fertility Clinic of Southeastern Wisconsin; Deaconess Hospital, Milwaukee)
Replantation Program (Dept Plastic and Reconstructive Surgery)
"VIAU-Feedback" (V-visual. I-interest, AU-audio) (Dept Physical Medicine & Rehabilitation)

UW Center for Health Sciences, Madison
Evaluation of Extracranial Cerebrovascular Disease Using Doppler Ultrasound (Dept Radiology)

UW Center for Health Sciences and Medical College of Wisconsin
The Lady with the Black Bag
The Library as Information Center (Todd Wehr Library, Milwaukee; Middleton Medical Library, UW, Madison)

State Medical Society of Wisconsin
The Impaired Physician (Commission on Mediation and Professional Ethics)
Wisconsin Physicians Planning Network (Commission on Health Planning)

Veterans Administration Hospital, Wood
Cerebral-evoked Potentials (William J Lajole, MD)

TECHNICAL EXHIBITS

Second Floor Convention Center (MECCA)
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†See Warnings, Precautions and Adverse Reactions.

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Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
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Scientific Medicine

Medical Editor: VICTOR S FALK, MD

Refer to: Raich PC, Traver MI: Therapeutic plasmapheresis. *Wisconsin Med J* 78:37-40 (Apr) 1979

Key words: Blood (plasmapheresis, immune complexes)

Therapeutic plasmapheresis

Peter C Raich, MD and **Myrna I Traver, MD,** Madison, Wisconsin

During the past year there has been a great resurgence of interest in the procedure of plasmapheresis (see recent editorial in *The New England Journal of Medicine,* November 24, 1977, Plasmapheresis; Great Economy in the Use of Horses). We read of dramatic responses in patients with resistent myasthenia gravis, near terminal Goodpasture's syndrome, and fulminant systemic lupus erythematosus. Favorable results also have been reported in schizophrenia and advanced cancer patients. What then is the true usefulness and what are the indications for this procedure?

Plasma exchange was first entertained in 1914 during attempts to develop an artificial kidney system.[1] In 1960 plasmapheresis was found to be strikingly effective in reducing manifestations of hyperviscosity in patients with Waldenström's macroglobulinemia.[2,3] During recent years, development of rather sophisticated cell separators has allowed for separation of individual blood components and for their selective removal as is the case with white cells and platelets, or for their exchange as is the case for plasma. By this means up to 4 liters of plasma can be removed and exchanged over a period of two to four hours and the exchange can be accomplished by using frozen plasma or various plasma substitutes. The major risk is that of hepatitis B transfer via the multiple units of fresh frozen plasma employed.

The major potential application of the plasmapheresis or plasma exchange procedure has been in situations of high circulating antibody or antibody-antigen complex levels. The improvement observed in such patients undergoing plasmapheresis should then be in direct relationship to the harm done by such antibodies or antibody-antigen complexes.

Indications for Therapeutic Plasmapheresis. The usefulness of plasmapheresis may presently be divided into three major categories according to the expectation of favorable response and the adequacy of previous trials:

I. Plasmapheresis is very effective in relieving the symptoms of hyperviscosity in patients with malignant paraprotein production, as in Waldenström's macroglobulinemia and in certain cases of multiple myeloma where the abnormal paraprotein forms larger and therefore more viscous aggregates.[2,3] We also have used plasmapheresis successfully in a patient with coagulopathy secondary to heavy chain disease. The excess plasma volume frequently present in patients with Waldenström's macroglobulinemia and multiple myeloma also may be reduced relatively easily by plasmapheresis. In addition to treatment of the hyperviscosity syndromes, plasmapheresis also has been helpful in diminishing factor VIII antibody (circulating anticoagulant) occurring in a

From the Departments of Medicine and Pathology, University of Wisconsin Center for Health Sciences, and the Clinical Laboratories, University of Wisconsin Hospitals, Madison. Publication support provided. Reprint requests to: Peter C Raich, MD, Room 4096 BSB, West Virginia University Medical Center, Morgantown, WV 26506. Copyright 1979 by the State Medical Society of Wisconsin.

significant number of hemophilia patients and in certain patients with systemic lupus erythematosus and related disorders. The use of plasmapheresis allows for a temporary reduction in the antibody titer, better control of the immediate bleeding problem by factor VIII concentrate, and more successful suppression of antibody formation subsequently with the concomitant use of cytotoxic therapy. This principle of therapy may well have application to other autoimmune diseases if plasmapheresis is able to trigger a synchronization of auto-aggressive lymphocytes which are then quite susceptible to cytotoxic chemotherapy.

II. Individual reports have appeared recently in the literature concerning the successful treatment of small numbers of patients with a variety of diseases which can be classified as "immune-complex" diseases. These include the treatment of thrombotic thrombocytopenic purpura patients refractory to steroids, splenectomy, and a variety of antiplatelet agents.[4,5] We recently have experienced good responses in two such patients attributable to plasmapheresis. In a recent report[5] evidence was presented that the improvement of a TTP patient's condition was related to supplying a missing factor, in that exchange transfusion using washed red cells and albumin instead of whole blood did not result in any improvement, while plasma exchange repeatedly induced improvement. It was postulated that the missing factor may be an inhibitor of platelet aggregation. There have been several reports of beneficial response in patients with refractory Goodpasture's syndrome treated with plasma exchange. It appeared that the effect was enhanced by concomitant immunosuppressive therapy.[6,7] Likewise, a portion of patients with acute systemic lupus erythematosus may respond to plasmapheresis. This seems to be true especially of patients who show suppressed complement levels suggesting the presence of high levels of circulating immune complexes.[8,9,10] In another report five of nine patients with fulminant immune-complex crescentic nephritis treated with both immunosuppression and plasmapheresis showed a rapid improvement in renal function. Improvement correlated with a decrease in circulating immune complexes.[11]

Other autoimmune disorders have been shown to respond to plasmapheresis; however, only sporadic cases have been reported. These include antibody-mediated aplastic anemia associated with systemic lupus erythematosus, autoimmune thrombocytopenia, and autoimmune hemolytic anemia.[12] We have seen a possible transient response of improved survival of transfused platelets following plasmapheresis in an aplastic patient on long-term platelet transfusion therapy. Plasmapheresis has been effective in preparing aplastic anemia patients for bone marrow transplantation with blood group incompatible donors. The use of plasma exchange transfusion for treatment of fulminant hepatic failure secondary to hepatic necrosis also has been documented.[13] Recently five patients with resistent myasthenia gravis were treated with plasmapheresis along with prednisone and azathioprine.[14,15] A marked improvement in muscle power was achieved following plasmapheresis along with a decrease in the levels of detectable antibody to acetylcholine receptor. Plasmapheresis also has been reported to effect a drop in Rh antibodies in sensitized Rh-negative women.[16,17] Five patients with disabling, refractory Raynaud's disease responded dramatically to plasmapheresis with resolution of prior digital artery occlusion.[18]

III. The documentation of beneficial effects due to plasmapheresis is even more tenuous in a number of other conditions. For example, immune (antigen-antibody) complexes have been detected in patients with myelofibrosis.[19] It is conceivable that the removal of such complexes may lessen the progression of fibrotic reaction in the marrow. There are other conditions where circulating antigen-antibody complexes may be responsible for a variety of tissue damage and might therefore benefit from plasmapheresis; however, no trials have yet been reported. These include rheumatoid arthritis,[20] Felty's syndrome, scleroderma, nephrotic syndrome,[21] idiopathic interstitial pneumonitis,[22] primary biliary cirrhosis,[23] Hodgkin's disease,[24] and unexplained coagulopathies. Also speculative at this time remain the possible uses of plasmapheresis in patients with cancer. "Blocking factors" have been documented in many patients with a variety of malignancies and these may play a role in the evolution of malignancy by protecting tumor cells from the surveillance mechanisms of lymphocytes or may blunt the lymphocytes' response to tumor antigens.[25] Such blocking factors may not necessarily be specific antibodies or antibody-antigen complexes,[25-28] but may be non-specific factors such as acute phase-reactive substances or sialoglycoproteins. These circulating factors then may obstruct the immune response by masking antigenic sites on the surface of tumor cells and/or the receptor sites on the surface of lymphocytes and macrophages. Although the levels of various abnormal serum protein fractions were shown to decrease during plasmapheresis in patients with a variety of cancers, the therapeutic effect was not striking, although a small portion of patients thus treated appeared to show a moderate temporary clinical improvement.[29,30] In another study,[31] cell-mediated cytotoxicity of patients' lymphocytes to melanoma cells was increased following plasmapheresis.

Although results of the use of plasmapheresis in cancer patients have thus far not been especially encouraging, a greater sophistication of measuring the effects of plasmapheresis along with the design for more selective removal and/or addition of factors may provide a more useful tool in the treatment of cancer patients.

Immune Complexes. The large numbers of disorders in which evidence for circulating complexes of antigen and antibody, or immune complexes, have been presented speaks to the intensity of work in this area. It is likely that immune complexes are present in the circulation of all normal individuals to assist in the elimination of foreign materials. In disorders associated with the formation of immune complexes, larger complexes are probably cleared by the reticuloendothelial system; however, smaller abnormal complexes persist in the circulation, are deposited in tissues, and may induce pathologic lesions. Many tests for the detection of immune complexes have been devised, often by indirect means depending upon various features of the antigen, antibody, and complement components.[32,33] In some disease states the level of complexes correlates with clinical activity and severity of the disease, and therefore may be valuable in assessing prognosis and monitoring therapy. If available, determination of serum immune complex levels before and after plasmapheresis is recommended to allow for correlation of such levels with changes in the patient's clinical status and to hopefully provide greater insights into the pathogenesis of such disorders.

Plasma exchange is greatly facilitated by the use of a blood cell separator. At our hospital an IBM® blood cell separator is available for the performance of therapeutic plasmapheresis, leukopheresis, and thrombopheresis. This machine allows for the 1:1 exchange of patient plasma with fresh frozen plasma, plasma substitutes, or saline solution. Constant attendance by trained personnel is required as well as a physician's supervision. Other similar equipment, such as the Haemonetics® or the Aminco® blood cell separator, are equally suited for therapeutic plasmapheresis.

Summary. The availability of sophisticated equipment which allows for the separation and the exchange of certain blood components has stimulated a recent interest in the therapeutic application of plasma exchange. In addition to the hyperviscosity syndrome, conditions associated with high levels of circulating immune-complexes may well benefit from such a procedure, especially if combined with immuno-suppressive cytotoxic therapy. Many therapeutic trials are only at a preliminary stage, and additional studies are required to document the true worth of this procedure.

At the present time the use of plasmapheresis as a therapeutic tool is definitely indicated only in those disorders listed in Section I. The disorders listed in Section II have been shown to be responsive to plasmapheresis with a reasonable certainty, but should be employed only after more conventional treatment is proved unsuccessful. The usefulness of plasmapheresis for conditions listed in Section III has not been documented and should remain on an investigational basis.

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Key words: Bone scintigraphy (infarction, blood supply, radiopharmaceuticals)

Bone scintigraphy: Long bone blood supply and collaterals

John R Sty, MD; Donald P Babbitt, MD and **Robert J Starshak, MD**
Milwaukee, Wisconsin

• **^{99m}Tc-labeled bone-seeking agents depend upon blood flow for localization. In sickle cell anemia patients with long bone infarctions, bone-seeking agents demonstrate the vascular ischemia as well as collateral vascular pathways.**

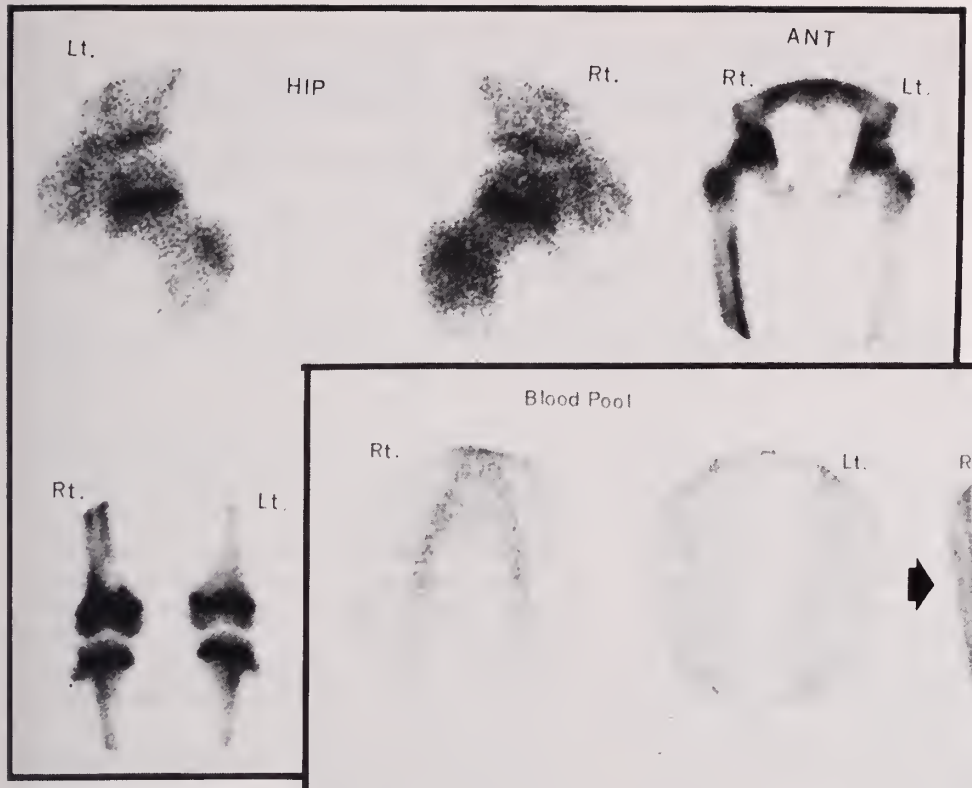
LONG BONES RECEIVE blood supply from a nutrient artery, periosteal arterioles, and metaphyseal arterioles.[1] The majority of blood supply is to the medullary canal from the nutrient artery.[2] The outer layers of cortical bone are supplied by periosteal vessels. There are numerous intracortical vascular anastomoses between the nutrient artery and periosteal vessels.[3] Collateral channels from the metaphysis to diaphysis have been documented in adult animals.[4] The potential of diaphyseal revascularization from the metaphysis is less documented in humans. With bone scintigraphy, the vascular supply to long bones and their collaterals can be demonstrated.

Methodology. 8.3 mCi/m^2 of ^{99m}Tc methylene diphosphonate was used for bone imaging. Blood pool and delayed images at two hours were obtained using a high resolution collimator.

Results. An 8-year-old (Fig 1) and a 10-year-old child (Fig 2), each with a recent sickle cell crisis and long bone infarction, illustrate the occlusion of the nutrient artery and revascularization from metaphyseal and periosteal collaterals. In Figure 2 the right distal femoral growth plate demonstrates the separate blood supply to the epiphysis. The epiphysis is normal and the metaphysis is hyperemic in response to the medullary infarction.

Discussion. Bone infarction is a common occurrence in sickle cell patients. Intravascular and sinusoidal sickling is potentiated by slow flow,

From the Department of Radiology, Milwaukee Children's Hospital, Milwaukee. Reprint requests to: John R Sty, MD, Dept of Radiology, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201. Copyright 1979 by the State Medical Society of Wisconsin.



◄ *FIGURE 1— Two-hour delayed bone images. Increased activity in the periosteum and metaphysis representing collateral blood supply (solid arrows). Recent infarctions (open arrow). The left hip, femur, and knee are normal.*

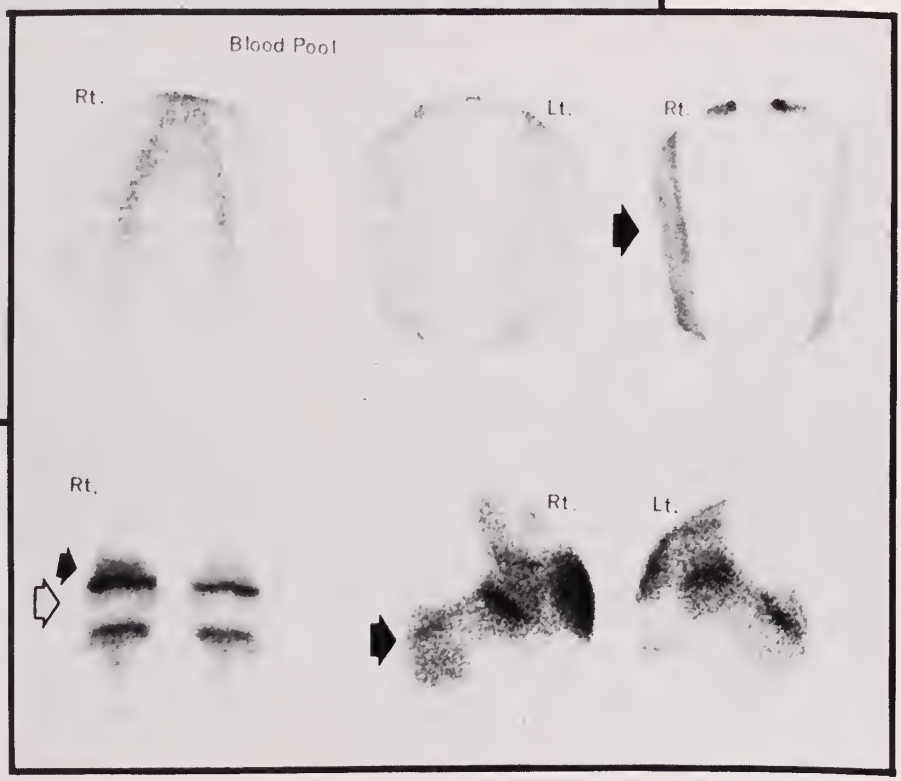


FIGURE 2 — Blood pool and two-hour delayed bone images. Normal blood pool. Increased activity in the periosteum and metaphysis (solid arrows). Normal activity in the epiphysis (open arrow). The open growth plate is the watershed between the metaphysis and epiphysis blood supply. ►

low oxygen tension, and lower temperature in the extremities.[5]

^{99m}Tc-labeled bone imaging agents depend upon blood flow for bone localization. Increased activity is noted when there is increased regional blood supply and/or bone turnover. Decreased activity is noted when vascularity is impaired or when bone is replaced.[6,7,8,9]

In early long bone ischemic necrosis, the radiopharmaceutical is not delivered to vascular segments supplying the bone and consequently a photon-deficient region results. Within five to seven days, the potential collateral vascular pathways attempt to restore blood flow to the ischemic region. This process is represented on the bone images as areas of increased activity. This is due to regional hyperemia.

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ONE OF A SERIES
COORDINATED BY

Richard C Brown, MD
Eau Claire, Wisconsin

MATERNAL MORTALITY
Yesterday-Today-Tomorrow

Frederick J Hofmeister, MD, FACOG
Wauwatosa, Wisconsin

THE JOY AND THRILL of becoming a parent can not fully be expressed in words. To touch and hold this new bit of humanity is beyond description. Although social factors can, at times, temporarily dim this experience, proper counseling and directive guidance by informed and concerned individuals can modify and eliminate the problem. Catastrophies associated with birth still occur. Mothers die. Infants die. No longer does the family charge these off to fate and indicate they were meant to be. They now ask, "Why?" "Who was at fault?".

Maternal mortality was always a concern of the physician who cared. The author and one of his residents, Doctor Stouffer, first reviewed maternal mortality at Milwaukee Hospital, now Lutheran Hospital of Milwaukee, in 1950.[1] The statistics for the years 1934-1949 are tabulated in Table 1. These reflect the numbers of deliveries and maternal deaths at Milwaukee Hospital at that time and are designated as deaths per 1,000 live births in Column A. They are also projected in this table, as presently designated, as deaths per 100,000 live births. Also in this table are the comparative figures for Milwaukee and Wisconsin. Are you able to imagine 276 maternal deaths per 100,000 live births? Or as indicated by the city of Milwaukee in 1936 through 1937, 360/100,000 live births and for Wisconsin 382/100,000 live births? These figures initiated the author's interest in the great problem of maternal mortality.

After considering these figures, it was imperative that something be done. When the Wisconsin Maternal Mortality Study Committee was created as a project of the Wisconsin Obstetrical and Gynecological Society, under the direction of the present Emeritus chairman of the Committee, Dr Thomas Leonard, the author became a part of that Committee. Numerous reports have been made relative to findings.[2,3] This presentation is an attempt to summarize the findings from its inception to 1977.

Table 2 illustrates graphically the number of live births and the maternal deaths detected during this period of time. Notice the decline of live births and maternal deaths through 1975 and then the sudden increase. During this period, there were 2,059,003 live births and 468 maternal deaths.

During this time, a new organization composed of representatives from North and South Dakota, Iowa, Minnesota, Wisconsin, Illinois, Indiana, Ohio, Kentucky, Michigan, and Ontario, Canada was created. This group, the Midwest Conference of Maternal Mortality Study Committees, is appealing for uniform terminology, a uniform death certificate that asks whether pregnancy was present or recently present at the time of death, and adoption of the Wisconsin Maternal Mortality Study Committee form with minor recommended additions. These additions are to be taken from the existent Michigan form. The Midwest group has agreed to this format. The author will present this recommendation before a national gathering of maternal mortality chairmen at the Annual Clinical Meeting of The American College of Obstetricians and Gynecologists to be held in April 1979 at New York City. We look forward to this improved form facilitating computerization. We, as a group, are appreciative to the Division of Maternal and Child Health of the State of Wisconsin and the Center for Disease Control in Atlanta. These groups have cooperated with great interest in this project.

Further statistics relative to the findings during the period 1953 through 1977 are as follows. These statistics further emphasize the importance of an accurate knowledge concerning maternal death. The responsibility factor must be considered. During the period surveyed, 1953 to 1977, the statistics indicate the following. Total physician responsibility decreased from 30% to 12%;

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hospital factors were 1.7% in the early analysis and decreased to 1%. Ten percent of the responsibility presently lie with the patient. A combination of lack of communication and coordination of efforts between patient and physician and hospital has been calculated to be 18% as a factor of responsibility. There are instances tabulated as high as 70% in which none of these factors relate.

It is necessary to note that in this entire period of study, 73% of the patients were multipara. Thus, one can say that from 1 to 12 infants were left without guidance and support of their mother if maternal death took the mother. The analysis indicates that the greatest number were white accounting for 82% of the deaths; 18% were nonwhite. Fifty percent of the maternal deaths occurred between the ages of 20 and 34 years. The patient under 20 years accounted for approximately 6% of maternal deaths. These statistics eliminate some of the opinions which infiltrate studies and may be instrumental in reducing enthusiasm in maternal and neonatal studies.

It is extremely important to accurately define maternal deaths. As an example, during 1977, 18 women who were either pregnant or had been pregnant in the immediate past, could be designated as maternal deaths but actually, three of these 18 were designated as nonmaternal deaths. They were pregnant but death was the result of a traumatic accident or suicide. It is necessary to have accurate definitions. Women who are pregnant or who have been pregnant within a period of 42 days and who die of coincidental disease, such as pneumonia or cancer, are designated as indirect maternal deaths. Four deaths were designated to be indirect maternal deaths. The remainder, 11, were direct maternal deaths. Thus, of the 18 maternal deaths, 15 were maternal deaths.

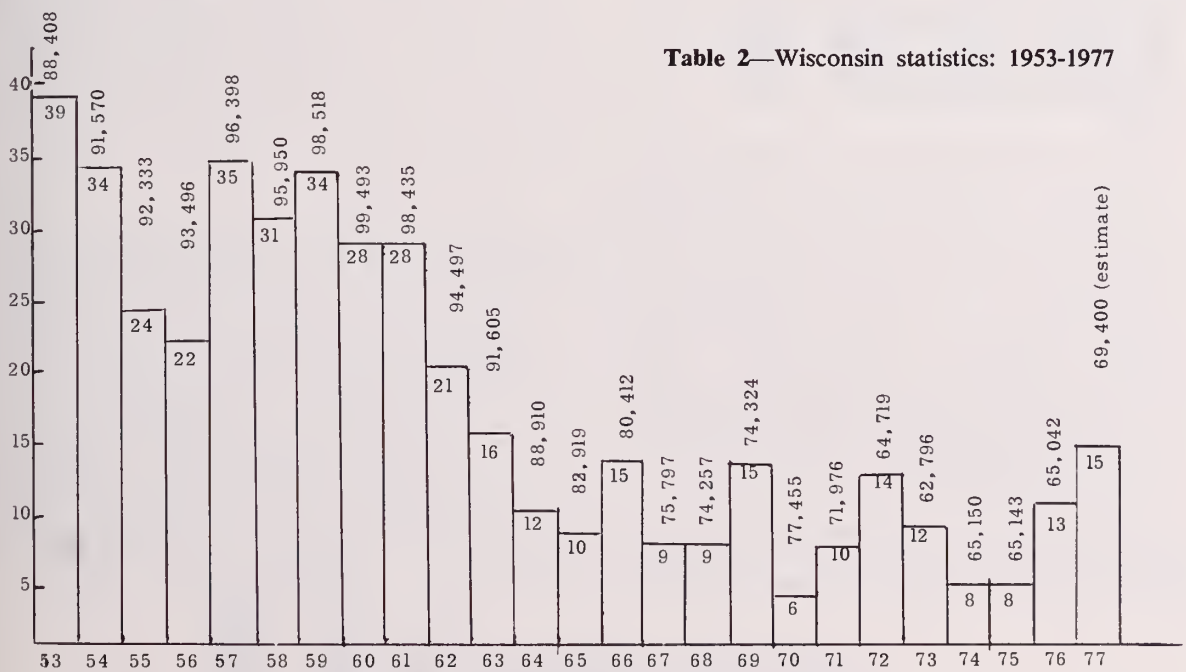
What about the great triad of maternal deaths; hemorrhage, toxemia and sepsis? Hemorrhage, which was the principal cause of death, accounting for 56.4% of maternal loss in 1953, has gradually decreased to 12%. Ruptured uterus is still a significant factor in the cause of hemorrhage. Sepsis, as a cause, is fluctuating and at one time had decreased to a cause of 12% of maternal deaths but recently accounted for 24.2% of maternal deaths. Toxemia has greatly decreased and accounts for approximately only 3% of maternal deaths. Wisconsin statistics point to the fact that causes listed as "Other" which include anesthesia, emboli, pulmonary and amniotic fluid, and coincidental disease involving the kidneys, heart, diabetes and malignancy, many of which

Table 1—Maternal Deaths

Per 1,000 live births (as then recorded) A
Per 100,000 live births (as now recorded) B

YEARS	MILWAUKEE HOSPITAL		CITY OF MILWAUKEE		STATE OF WISCONSIN	
	A	B	A	B	A	B
1934-1937	2.76	276	3.6	360	3.82	382
1938-1941	1.05	105	2.5	250	2.74	274
1942-1945	0.69	69	2.03	203	1.72	172
1946-1949	0.37	37	1.10	110	0.99	99

Table 2—Wisconsin statistics: 1953-1977



are present in the prepregnancy state, accounted for 60% of the deaths reviewed. It is important to note that in an analysis of 14 deaths due to amniotic fluid emboli from 1968 to 1974, Doctor Leonard found that 12 of these deaths were oxytocic related. Medical judgment and care must influence the use of oxytocics or maternal deaths can result.

Wisconsin has always felt that maternal mortality studies are important. The Study Committee has been active in determining maternal deaths and stimulating educational efforts to combat maternal deaths. It must be noted that the maternal death rate, which during the years 1953 to 1967 was 26.156/100,000, fell to 15.8/100,000 live births during the years 1970 to 1977. During the entire period, 1953 to 1977, the maternal mortality rate has averaged 22.76/100,000 live births. Thus, it is evident that progress has been made. Progress must continue. Mothers and infants will benefit. It must be remembered: "The normality of obstetrics is its most dangerous feature. It demands that the physician be constantly on the alert."[4]

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Abstracts

Regional problems in respiratory diseases

Three Wisconsin authors from the University of Wisconsin had articles in a recent publication, *Regional Problems in Respiratory Diseases,* Volume 1, Number 2, published by Geigy Pharmaceuticals as a service to the medical profession. The authors and abstracts of the articles follow:

Farmer's lung disease, by *Sheldon R Braun, MD,* Madison: In the patient with farmer's lung disease, onset typically occurs four to six hours after working with moldy materials, with the development of fever, chills, dyspnea, and general malaise. Known exposure to moldy materials, followed shortly by an acute episode, together with compatible chest roentgenograms and pulmonary function studies, are highly suggestive of the diagnosis. The disease must be differentiated from silo filler's disease.

Silo filler's disease, by *Guillermo doPico, MD,* Madison: The incidence of silo filler's disease is difficult to assess, and its true scope is probably underestimated. The disease is caused by inhalation of nitrogen dioxide, which on farms may be derived from plant materials stored in silos. Mild exposures to nitrogen dioxide cause upper airway and ocular irritation, cough, dyspnea, fatigue, cyanosis, vomiting, vertigo, somnolence, and even loss of consciousness. More severe exposure may result in death from bronchiolar or laryngeal spasm, reflex respiratory arrest, or simple asphyxia.

Acute histoplasmosis occurring after sawing wood, by *Helen A Dickie, MD,* Madison: Six individuals with acute histoplasmosis are described in whom the only reasonable source of exposure to *Histoplasma capsulatum*, the causative agent, was in wood that they were sawing. In three patients the recovery of *H capsulatum* from wood samples, as well as isolation of the organism from sputum and gastric lavage, pinpointed the source. In another patient serologic evidence implicated *H capsulatum.* As wood becomes a more frequent alternative energy source, it is likely that more individuals will be so infected. ■

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ANNUAL MEETING: May 18-20, Eau Claire

THE WISCONSIN SOCIETY of the American Association of Medical Assistants will hold its Annual Meeting on May 18, 19, 20, 1979 at the Midway Motor Lodge, Eau Claire, Wisconsin. Eau Claire and Polk-St Croix Chapters will be hostesses for this event. The theme for this meeting will be "LIGHT UP YOUR LIFE."

The preconvention Executive Board Meeting on Friday, May 18, will precede a luncheon for the delegates. The House of Delegates will meet on Friday afternoon to conduct the business of the Society, elect new officers and update the Constitution.

On Saturday, May 20, education will be the main topic, following a welcome to the group by President Jane Dowds, CMA, A-C and Donald R Griffith, MD, Midelfort Clinic, Eau Claire.

The two-hour morning session will feature "Family Abuse-Child Abuse" by Dr Steven Bavolek, University of Wisconsin, Eau Claire. The first afternoon session will be "The Role of Physician Assistant/Medical Assistant in the Health Care Field," by Mr Lou Falligant, Physicians Assistant, Wright Clinic, Mondovi. Mabel Ann Veech, National Trustee, AAMA will be speaking on "Career vs Family Life" at the second session. Continuing Education Units will be given to all participating members who pass the examinations following each presentation.

The formal banquet will be held Saturday night with the installation of officers. President Jane Dowds of Janesville will pass the gavel to the new President, Alma Allen of Racine. Racine Chapter will honor the new President with a reception following the banquet.

A Sunday morning Ecumenical Church service will precede brunch. The report of the House of Delegates Meeting will be given and the new President will announce her committees. Following announcements, the meeting will adjourn and members will travel their various ways.

—LILA CHAMBERLAIN and GEORGIA FERN, CMA
Cochairmen, Annual Meeting ■

NOW IT'S WOGGING—NOT WALKING OR JOGGING

Thomas W Patrick Jr, MD of Hastings on Hudson, New York, is writing a book on wogging (walking for pleasure, exercise, and physical fitness, at different rates, from brisk to rapid). Wogging is his own, wholly original term, formed by combining the "w" in "walking" with the "ogging" in "jogging." Doctor Patrick is interested in receiving any information or published articles on walking for health and pleasure. He writes: "Wogging is especially recommended for those persons who won't, can't, or possibly shouldn't run or jog. Among these are: most individuals over 60 years of age, those with cardiovascular or pulmonary conditions, postoperative patients, the obese, and those with orthopedic conditions. Actually, however, wogging is good for everyone. Extensive observation has indicated that almost all those persons who are introduced to wogging respond enthusiastically, perhaps because of the timely, eye and ear catching attractiveness of the word, which gives an entirely new concept to walking for pleasure and health—a near, needed, and less strenuous relative of jogging, as it were." His address is: 100 Pincrest Drive, Hastings on Hudson, NY 10706. ■

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Cancer Column

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Hyperthermia—Progress through basic research

RECENTLY THERE HAS been an increased interest in the use of heat (hyperthermia) to treat human cancers. Studies in various parts of the world have raised the hopes of many physicians that hyperthemia will prove to be another valuable tool for treating cancer. A combination of hyperthermia with chemotherapy or radiotherapy holds special promise. But in order to make a rational choice of treatment and provide the optimal treatment for each cancer patient, the physician needs to understand the mechanism of action which causes killing of cancer cells by heat.

To gain this knowledge, basic research scientists at the Wisconsin Clinical Cancer Center in Madison are trying to determine if heat kills cells by altering the properties of the lipids in their cell membranes. As early as 1924, Heilbrunn suggested that there was a relationship between the temperature at which organisms die and the melting point of the lipids in the cell membrane.

Using an *E coli* K12 unsaturated fatty acid requiring mutant, Doctors Melton Yatvin and W H Dennis of the Wisconsin Clinical Cancer Center, found that the composition of the membrane changed and became more fluid when the bacteria were grown in a media containing more highly unsaturated fatty acids. Increased incorporation of unsaturated fatty acids into the membranes also increased the amount of killing when the bacteria were exposed to heat that was only a few degrees above their normal growth temperature of 37 C. The amount of killing and the fluidity of the membrane increased as the lipid unsaturation increased; that is, cells grown in oleic acid (one double bond) were more heat resistant than those grown in linoleic acid (two double bonds), while those grown in linolenic acid (three double bonds) were the most sensitive and had the most fluid membranes. Their general biochemistry and protein contents did not appear to vary, but their survival in the presence of increased temperature decreased rapidly as the amount of unsaturated fatty acids incorporated increased.

Local anesthetics, such as procaine and lidocaine, have been shown to alter the viscosity of the lipids in cell membranes. Doctors Yatvin and Dennis showed that these drugs also increase the killing of mutant *E coli* with heat. They consistently increase the killing over and above the effect of lipid composition on the membrane, possibly due to membrane lipid disorganization causing increased microviscosity of the membranes. Lidocaine appears to produce similar changes at a lower concentration than procaine.

These basic science studies suggest that drugs and nutritional factors can decrease the degree of membrane organization, thus increasing the susceptibility of cells to hyperthermic killing. Local perfusion of a tumor with a local anesthetic may decrease the hyperthermic temperatures and exposure times needed to kill tumor cells and possibly help reduce the hyperthermic injury to normal tissues during treatment.

To more closely simulate conditions in the human body, studies were done using Chinese hamster lung cells. These cells were more sensitive to hyperthermia when treated with procaine. Doctors Kelly Clifton, Yatvin, and Dennis treated mice bearing mammary adenomas with lidocaine, then heated them at 43.5 C for one hour. Survival of the treated mice was better (time to 90% mortality with 40.8 days with three mice surviving over 120 days) than that of untreated animals or those treated at 42 C for an hour (all were dead 30 days after hyperthermic treatment).

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

Hyperthermia alone at 43.5 C increased the time to 90% mortality from 17.2 days to 26.5 days.

Ideally a cancer chemotherapeutic drug should be delivered directly to a tumor rather than circulating throughout the body and indiscriminately affecting both normal and cancer cells. It occurred to Doctor Yatvin that liposomes might make this possible. Liposomes are man-made microscopic particles which have a lipid bilayer enclosing an aqueous compartment. To see if local hyperthermia might affect liposomes at temperatures near their liquid-crystalline transition temperature and permit them to release their contents, liposomes were designed to become leaky at a temperature in the range attained with mild local hyperthermia using dipalmitoyl phosphatidylcholine and distearoyl phosphatidylcholine with neomycin in the aqueous compartment. Release of the neomycin at 42-44 C was detected by measuring the inhibition of radioactive leucine uptake by *E coli*. Liposomes are being developed which will selectively release chemotherapeutic drugs locally into a tumor when subjected to hyperthermia.

In another experiment the bacterial cells were grown in various fatty acids, then exposed to ionizing radiation. The cells also were treated with hyperthermia both before and after the radiation. In all cases the effect of radiation on cell survival appeared to be independent of the effect of the hyperthermia, suggesting that a combination of hyperthermia with radiotherapy might be used to increase the effectiveness of cancer treatment.

These basic research scientists hope that these experiments on the structure of cell membranes, their sensitivity to heat, and the use of liposomes to permit local concentration of drugs in tumors subjected to heat will permit hyperthermia to become a useful method of treating cancer. Basic science research studies are showing how chemotherapy, radiotherapy, and hyperthermia can be combined to increase the therapeutic capabilities of the oncologist—DOROTHY J BUCHANAN-DAVIDSON, PhD, Science Writer

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See YELLOW PAGES for information on Midwest Head and Neck Cancer Seminar, June 7-8, 1979, at the Concourse Hotel in Madison. ■

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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Direct Medical Inquiries to.
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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For prescribing information see opposite page

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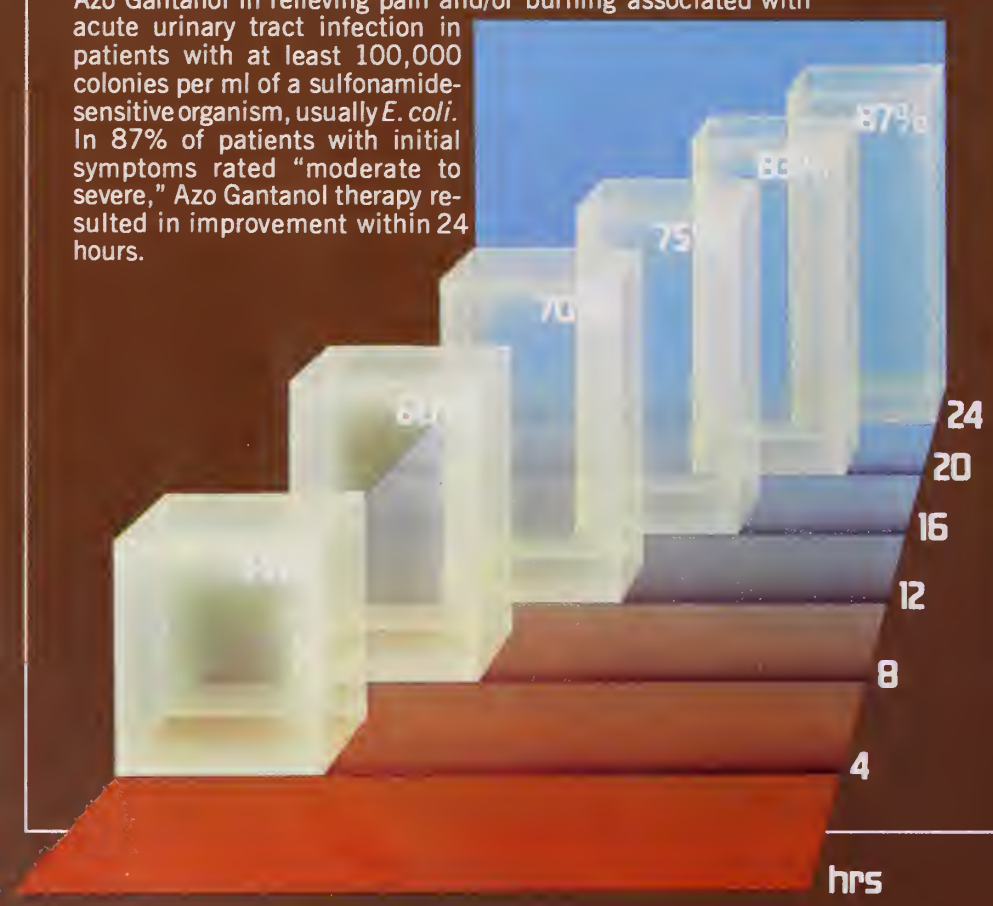

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for the pain **for the pathogens**

*Data on file Hoffmann-La Roche Inc. Nutley, New Jersey 07110.

Before prescribing, please consult complet uct information, a summary of which follo

Indications: In adults, urinary tract infecti complicated by pain (primarily pyelonephr pyelitis and cystitis) due to susceptible or (usually *E. coli, Klebsiella-Aerobacter, Sta coccus aureus, Proteus mirabilis*, and, les quently, *Proteus vulgaris*) in the absence obstructive uropathy or foreign bodies. N fully coordinate *in vitro* sulfonamide sen tests with bacteriologic and clinical respo aminobenzoic acid to follow-up culture m increasing frequency of resistant organism the usefulness of antibacterials including fonamides. Measure sulfonamide blood le variations may occur; 20 mg/100 ml shou maximum total level.

Contraindications: Children below age 12 fonamide hypersensitivity; pregnancy at t during nursing period; because Azo Gant tains phenazopyridine hydrochloride it is dicated in glomerulonephritis, severe hep uremia, and pyelonephritis of pregnancy disturbances.

Warnings: Safety during pregnancy not e Deaths from hypersensitivity reactions, a tosis, aplastic anemia and other blood dy have been reported and early clinical si throat, fever, pallor, purpura or jaundice) dicate serious blood disorders. Frequent urinalysis with microscopic examination ommended during sulfonamide therapy.

Precautions: Use cautiously in patients paired renal or hepatic function, severe bronchial asthma; in glucose-6-phosphat dehydrogenase-deficient individuals in dose-related hemolysis may occur. Maint adequate fluid intake to prevent crystall stone formation.

Adverse Reactions: *Blood dyscrasias* (ag ulocytosis, aplastic anemia, thrombocyto leukopenia, hemolytic anemia, purpura, thrombinemia and methemoglobinemia) *reactions* (erythema multiforme, skin er Stevens-Johnson syndrome, epidermal n urticaria, serum sickness, pruritus, exfo dermatitis, anaphylactoid reactions, per edema, conjunctival and scleral injectio sensitization, arthralgia and allergic my *G.I. reactions* (nausea, emesis, abdomi hepatitis, diarrhea, anorexia, pancreatit stomatitis); *CNS reactions* (headache, p neuritis, mental depression, convulsion hallucinations, tinnitus, vertigo and ins *miscellaneous reactions* (drug fever, chi nephrosis with oliguria and anuria, peri nodosa and L. E. phenomenon). Due to chemical similarities with some goitro uretics (acetazolamide, thiazides) and glycemic agents, sulfonamides have ca instances of goiter production, diuresis glycemia. Cross-sensitivity with these a exist.

Dosage: Azo Gantanol is intended for t painful phase of urinary tract infections *adult dosage:* 2 Gm (4 tabs) initially, t (2 tabs) B.I.D. for up to 3 days. If pain causes other than infection should be After relief of pain has been obtained, treatment with Gantanol (sulfamethoxa be considered.

NOTE: Patients should be told that the dye (phenazopyridine HCl) will color th

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Health Planning

Editor: DOUG NELSON
Director, Health Services Division

New CON thresholds worked out by SMS/DHSS

DOLLAR THRESHOLDS for clinical equipment under Wisconsin's Certificate of Need (CON) law will be raised to reflect increases in the Consumer Price Index (CPI), according to a recent agreement negotiated by the State Medical Society and the State Department of Health and Social Services.

Currently physicians' offices are covered under CON only when there is a capital expenditure for a single piece of clinical equipment costing more than $100,000 or a capital expenditure for two or more pieces of related equipment costing in excess of $150,000 when at least one of the pieces costs more than $100,000. The CON law provides that these capital expenditure thresholds are negotiated with the State every two years under the premise that an increase in the cost of clinical equipment should signal a change in the thresholds. While there have been very few CON applications for clinical equipment in physicians' offices, the Society's Commission on Health Planning insisted that the threshold be raised to reflect the CPI increase.

Under the new agreement, the threshold for a single piece of clinical equipment will be raised from $100,000 to $117,000. This increase is based on changes in the CPI between July 1977 and July 1979. The $150,000 threshold will remain the same so that it is consistent with the $150,000 hospital threshold which is set by federal law. The agreement worked out by SMS and the Department of Health and Social Services has been transmitted to the Legislature's Joint Finance Committee which must initiate the appropriate statutory changes.

Physicians must apply and obtain approval from the Bureau of Needs Review in the DHSS in order to purchase clinical equipment which exceeds dollar thresholds set by state statute.

MD Task Force established in HSA District 1

Another step was taken toward establishing the Wisconsin Physicians Planning Network (WPPN) March 14 when the Physician Task Force of the Health Systems Agency District 1 (Health Planning Council Inc) met for the first time at SMS headquarters in Madison.

Fifteen physicians appointed by hospital medical staffs and county medical societies within the HSA district were present to discuss the group's involvement in health planning activities during the coming year. Jan E Erlandson, MD, Monroe, was elected chairman of the Physician Task Force.

Other physician task force members were: Doctors Frederick C Kriss, Robert A McDonald, S Craighead Alexander, John B Toussaint, and George H Handy, all of Madison; Paul F Frechette and P Richard Sholl, Janesville; Timothy A Correll and Nathaniel G Rasmussen, Dodgeville; Paul R Glunz and Norman Schroeder II, Beaver Dam; Kenneth I Gold, Beloit; Ross L Cline, Monroe; and John T Siebert, Baraboo.

Also present at the meeting was Paul Fleer, executive director of the Health Planning Council Inc, who praised the creation of the task force and said that the Council "welcomed physician assistance in the planning process."

The Task Force will be involved in developing the 1980 HSA health systems plan and will assist in making recommendations to the HSA on Certificate of Need applications.

Eleven counties comprise the HSA District 1: Grant, Lafayette, Green, Rock, Jefferson, Dane, Iowa, Richland, Sauk, Columbia, and Dodge.

The Lake Winnebago HSA District 3 was the first to establish a Physician Task Force, having

envisioned the need some two years ago.

Plans are in progress for the establishment of a physician task force in each HSA area. Liaison will be maintained with the State Health Policy Council and other state health planning agencies. The WPPN is being organized with the assistance of county medical societies and hospital medical staffs.

In a related development . . . The Medical Society of Milwaukee County's Hospital Medical Staff Liaison Committee, March 15, endorsed the Wisconsin Physicians Planning Network. The Milwaukee Committee recommended that all Milwaukee hospital medical staffs name a representative to the Southeastern Wisconsin Health Systems Agency Physician Task Force. The SEWHSA Physicians Task Force is expected to be established by the beginning of June.

And a reminder . . . If your county medical society or hospital medical staff hasn't scheduled the audiovisual presentation on the Wisconsin Physicians Planning Network, contact Neal Neuberger at the SMS Health Services Division in Madison: 257-6781 or toll-free 1-800-362-9080.

New UW film explores rural health care

At its March 8 meeting, the Commission on Health Planning reviewed a new University of Wisconsin film that examines the experiences of five rural Wisconsin communities which have suffered physician shortages. Entitled "Delivery of Medical Services in Rural Areas," the film documents both the successes and failures these communities have had in providing medical care services to local citizens. The film can be rented for a $7 fee through the UW-Extension's Bureau of Audio-Visual Instruction, Box 2093, Madison, Wis 53701.

Following the presentation the Commission approved a recommendation that the State Medical Society become more active in helping to develop adequate health care systems for rural shortage areas by:

1. Providing consultation to medical schools and the Health Policy Council;
2. Acting as a catalyst for the development of rural health systems;
3. Functioning as an informational resource; and
4. Acting as a placement agency for health personnel, including nurse practitioners and physician assistants.

The Commission felt this should be accomplished by enlisting the help of physicians who now serve in rural shortage areas since they know the kinds of problems that exist.

Members attending the March 8 meeting of the Commission on Health Planning were Doctors Marvin G Parker, Racine, chairman; Guenther Pohlmann, Milwaukee; Donald R Korst, Madison; John E Ridley III, Milwaukee; Michael J Mally, Hartford; Albert M Cohen, Milwaukee; Robert A McDonald, Madison; John T Mendenhall, Madison; John L Melvin, Milwaukee; Lawrence Hipshman, Middleton; David E Goodnough, LaCrosse; and Kurt R Martyn, Madison.

Health Planning Physician conference changed to Fall

A two-day conference on health planning, its effect on medical practice, and the potential for physician involvement, originally scheduled for June 8-9, has been changed to Fall. More information will be reported in the May issue. ■

—Diane Upton, Communications Dept

SURVEY LOOKS AT ECONOMICS OF MEDICAL PRACTICE

The average US physician in office practice in 1976 was 46 years of age, worked 52.2 hours per week, and averaged $59,544 in income, according to results published in the *1978 Profiles of Medical Practice*. Compiled by the AMA's Center for Health Services Research and Development, the new seventh edition of the book is based in large part on information from the 11th Periodic Survey of Physicians. Among the findings of the AMA Reference Book are: • Since 1975 the rate of increase of physicians' fees, as measured by the Consumer Price Index, has been declining, to 9.2 percent in 1977. • For the typical physician, practice expenses increased at a compound rate of growth of 10.4 percent, 1969-1976, while net income from medical practice increased at a rate of 6.0 percent over the same period. • The average physician in 1976 was seeing more patients—128.5 per week—as compared with 126.5 in 1976 and 125.8 in 1974.

Profile of Medical Practice 1978 is available from the AMA Order Dept. OP-52, American Medical Association, PO Box 821, Monroe, WI 53566. Individual copies are $5.00.

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Physicians Alliance

Editor: BRIAN JENSEN
Director: Physicians Alliance Division

State DHSS finalizes Super-Rule

For several months the Society's Physicians Alliance Commission and Staff have been deeply involved in the progress of the Medical Assistance Rule Recodification (Super-Rule). Many of the deliberation's have been reported in the T-19 Update supplement to Medigram. The State Department of Health and Social Services submitted its final draft of the rule in mid-March to the Revisor of Statutes for publication.

An initial review of the Super-Rule by Physicians Alliance Staff indicates the following changes made by DHSS in accordance with the Society's position on the Rule:

- "Consultation" has been redefined by DHSS to allow for it as a covered service whenever documentation of a face-to-face encounter by a second physician is provided. "Curbside" or informal discussion between two or more physicians will not be reimbursed.
- "Retroactive eligibility" of a recipient will be expressly limited to 90 days in the Rule; previous drafts did not contain such a specific limit.
- Changes in a physician's "Board Certification" will not be considered as a change for licensure/certification purposes.
- Medical records of recipients need not include an actual copy of prescriptions written by a physician; only notification in the record will be required.
- Whenever a physician provides "emergency" treatment and the physician has *not* signed a T-19 agreement, the physician may bill the Program on a special form and the claim will be treated as a "good faith" claim. Previous drafts of the Rule would have required the physician to also submit a signed agreement and an application for certification.
- DHSS policy will now allow a provider to also question and appeal the denial of a prior authorization request; the earlier Rule restricted that appeal right only to recipients.
- Records of services/items to recipients must be retained for five years from the date of payment; earlier drafts required a six-year retention.
- Sections of earlier drafts relative to "involuntary" termination would have prohibited any provider connected in any way with a provider violating any part of the Rule from participating for five years. The final draft alters this language to insure only the "guilty" party is so terminated, not partners, other service corporation members, or clinic members.
- Two sections have been added to the Rule to allow DHSS to grant "waivers" or "variances" to any section of the Rule upon satisfactory demonstration of an "intent" to comply with state or federal laws/regulations. This primarily applies to institutions rather than individual providers.

In spite of these changes, several areas of the Rule remain unresolved:

- The Rule has not been amended to make it clear that any provider has a right to refuse to treat a recipient for any reason except for conditions outlined in the Civil Rights Act of 1964. The Rule includes a "Recipient Right of Free Choice" but not a "provider" free choice clause. The Physicians Alliance has learned that draft federal regulations will be issued shortly to accomplish this. In the event the federal activity fails to satisfy the Alliance, remedial legislation will be prepared.
- The entire area of "excess payments" and deductions from future claims for overpayment has not been adequately resolved. However, EDS-Federal—the T-19 (Medicaid) intermediary—is attempting to resolve this problem with both the Alliance and DHSS.
- While the Rule and statutory law clearly state that only Medical Assistance records may be reviewed by DHSS inspectors (or Department of Justice in the event of a fraud investigation), the Alliance attempted, and failed, to clearly indicate that the record review activity must be "on-site" inspection only. DHSS has agreed that any costs connected with reproduction of records will be borne by the Department.

• **Psychotherapy:** Under the final draft, only four categories of providers will be able to provide psychotherapy:

A. Physicians who have completed a residency in psychiatry or who are certified by the American Board of Family Practice.

B. Licensed psychologists who are listed or eligible to be listed in the National Register of Health Service Providers in Psychology.

C. Outpatient facilities operated (contracted) by a 51.42 Unified Services Board.

D. Outpatient facilities operated by a provider hospital certified by DHSS and accredited by JCAH.

Other "non-billing" providers (social workers [MSWs], psychiatric nurses, etc) may only provide psychotherapy under C. and D. above. That is, these providers may **not** deliver psychotherapy even under the prescription and supervision of a psychiatrist, family practitioner, or licensed psychologist.

Due to the importance of the problem areas still existent in the Rule, the Physicians Alliance Staff will be meeting with key legislators during the coming weeks to gain support for an appeal to the Joint Committee for the Review of Administrative Rules or the Joint Committee on Finance for changes in the Rule.

Alliance Commission meets with Surgical-Care-Blue Shield

SURGICAL CARE-BLUE SHIELD's five-percent physician reimbursement limit and its determination of customary, usual, and reasonable (CUR) charges were the primary topics of discussion at a March 16 meeting of the SMS Physicians Alliance Commission and Surgical Care-Blue Shield President Thomas Girard.

At that meeting, several members of the Commission questioned Surgical Care's use of CUR as determined by the carrier and the carrier's rejection of some physician claims as "unreasonable" charges. Mr Girard pointed out that about 90 percent of all physician claims are processed without difficulty and are within the CUR determinations made by the company.

The Commission also raised objections to letters Surgical Care sends to subscribers suggesting that patients are not liable for charges beyond the CUR as determined by Surgical Care unless prior agreements were made between physician and patient.

The Physicians Alliance Commission has requested Staff to develop a plan advising physicians about the CUR determinations and methods used by Surgical Care to convince subscribers that the policy purchased would pay all physician charges. ■

—DIANE UPTON, Communications Dept

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Medicinal marijuana legislation considered

State Rep Ronald Lingren (D-Menomonee Falls) met with the SMS Commission on Governmental Affairs March 14 to discuss Assembly Bill 107, a bill he has introduced allowing the use of marijuana and its derivatives for therapeutic research on patients suffering from glaucoma or side effects of chemotherapy.

Under the proposed bill, the Department of Health and Social Services would contract with the National Institute on Drug Abuse for receipt of the marijuana, and would then transfer the drug to pharmacies for distribution to certified patients. The proposal also sets up a Patient Qualification and Review Board which would certify patients to participate in the program.

Presently the federal government will authorize marijuana for research purposes, but it has not approved marijuana for medical treatment.

The Commission decided not to support the bill at this time because research is already being done by the National Institutes of Health, medical schools, and other states. While the Commission felt marijuana should continue to be used in medicinal research, the costs incurred in Rep Lingren's proposal would be duplicative to studies being conducted elsewhere.

In rejecting the bill, the Commission said it was not convinced that a serious enough health problem exists in this area to warrant Medical Examining Board licensing. ■

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INDICATIONS: *Therapeutically,* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

County Societies

Brown CMS sponsors media relations program

Brown County Physicians and news media people got together in March to discuss their individual responsibilities regarding the accurate reporting of medical news and how to develop a good working relationship between the two professions.

At a special meeting of the Brown County Medical Society formal presentations were made by representatives of television, radio, newspapers, and the medical profession, followed by a panel discussion and a question-answer session.

According to Herbert F Sandmire, MD, Green Bay, chairman of the SMS Commission on Public Information, the joint meeting was quite successful in that persons representing the media and the medical profession felt it helped to "enhance understanding between the respective professions."

"Media personnel noted their continual problem in finding local physicians who were willing to be interviewed by the press on a given news story," Doctor Sandmire explained. "I think that as a result of this meeting physicians might be more willing to speak out in the press on current health issues, and likewise the news media may actively solicit the medical viewpoint on some stories that it otherwise would have run without local medical comment," he said.

A few days following this medical/media forum, the Brown County Medical Society voted to:

1. Encourage local county medical society physicians to cooperate with news media in providing information of medical interest.
2. Communicate to local hospitals that they should provide news media with the name of the attending physician in a case, provided they have the attending physician's permission.
3. Provide all local media outlets with a list of county medical society officers and other physicians who will serve as media contact persons to assist in the selection of a physician to comment on a given news story.

The SMS Public Information Commission and the Brown County Medical Society encourage other county medical societies to sponsor similar medical/media programs in their areas. Any county medical society interested in sponsoring such a program can get assistance by contacting Diane Upton at the SMS Communications Department in Madison: 257-6781, or toll-free 1-800-362-9080.

In addition, the American Medical Association Office of Public Relations has a booklet available which provides local county medical societies with the basic elements of good media relations. Copies of the booklet: "You, Too, Can Have a Good Media Relations Program," may be purchased from: Order Dept OP-434, American Medical Association, PO Box 821, Monroe, Wis 53566. ■

—Diane Upton, Communications Dept

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Organizational SMS

Council acts on many issues

Meeting in Madison April 7 the Council of the State Medical Society approved production of a pamphlet: "If You Have a Complaint About Medical Care," prepared by the SMS Commission on Mediation and Professional Ethics.

The pamphlet informs both physicians and the public of the means by which a medical complaint may be presented and handled before the Commission on Mediation and Professional Ethics. It will be distributed to physicians, complainants, and consumer groups.

The Council also approved a new protocol manual for the Commission to help assure "due process" in the handling of complaints.

In other action April 7 the Council:

• Approved continued participation by SMS in the AMA Jail Health Care Project in Wisconsin, assuming federal funding continues.

• Will invite representatives of the Wisconsin Academy of Family Physicians to attend the May 9 Council meeting (in Milwaukee) to present their views and recommendations relative to the report of a review committee on the UW Department of Family Medicine and Practice.

• Recommended that the Wisconsin Delegation to the AMA introduce a resolution to the AMA House of Delegates asking it to study alternative membership structures. The resolution will first be submitted to the SMS House for concurrence.

• Set the following dates for Council meetings during 1979-80: July 14, September 8, November 17, January 19, and March 26. 1980 Annual Meeting is March 27-29.

• Agreed that subscriptions to the *Wisconsin Medical Journal* are available to nonmember individuals at an annual subscription rate of $40.

• Urged that state laws concerning release of private patient records conform to the principles of patient-doctor privilege (confidentiality) but with specifically designated categories of information that can be released without prior authorization of the patient, such as those dealing with emergencies, accreditation, and peer review.

• Instructed the SMS Physicians Alliance to seek legislation clearly designating the State Medical Society as a peer review agency, thereby granting SMS specific immunity for its peer review functions.

• Opposed an unlimited discovery rule in malpractice actions; but voted to support "if reasonable and necessary" a limited discovery rule.

AB 327 was opposed. It allows a malpractice action to be filed within 3 years after the "injured" person becomes aware or reasonably should have become aware of the injury. This would hold open the opportunity for discovery for the lifetime of the patient.

AB 326 was supported "if reasonable and necessary." This would allow a malpractice action to be commenced not later than 3 years from the date of the injury, or not more than 1 year from the date the injury was discovered or should have been discovered, but in no event more than 6 years from the date of the act or omission. Concealment by the physician or foreign objects constitute a cause for action within 1 year of discovery no matter how long after the alleged malpractice act.

• Asked the SMS Committee on the Evaluation of the Delivery and the Cost of Medical Care to study the issue of "fragmented billing" by physicians and to recommend whether the Council should adopt an official SMS policy statement.

• Asked the SMS Commission on Mediation and Professional Ethics to prepare a letter for Council review, expressing the Society's concern to a physician regarding his practice patterns.

• Approved guidelines for extending hospital privileges to a nurse engaged in joint practice with a physician. These were prepared by the Joint Practice Committee of the Wisconsin Nurses Association and the State Medical Society of Wisconsin.

• Accepted guidelines on "Cardiac Aspects of School Bus Operation" as developed by the State Department of Public Instruction and the State Division of Motor Vehicles with the recommendation of the SMS Committee on Safe Transportation.

• Recommended to the Wisconsin Review Foundation Board that it create a single unified board for both public and private review with the Board membership to be elected by WisPRO members. The Council further recommended to WRF that it create a liaison committee with the SMS Council on private review activities. At present, WRF and WisPRO have separate Boards of Directors, with WRF determining private review policy and WisPRO setting public (PSRO) review policies.

• Agreed to introduce a resolution to the 1979 House of Delegates reaffirming earlier Society encouragement and help to all communities seeking to establish diploma nursing schools, and encouraging nursing education at all levels including degree schools, diploma schools, and schools for licensed practical nurses.

• Accepted a recommendation by the Finance

Committee to raise 1980 SMS dues $25 in accordance with a 1978 House of Delegates action allowing for future dues increases commensurate with increases in the Consumer Price Index.

• Granted Howard L Correll, MD, Arena, honorary membership in the State Medical Society.

• Approved a rule stating that if a "member of an SMS committee or commission is absent without excuse from three consecutive meetings, his or her resignation shall be deemed to have been tendered and accepted." ■

SMS annuity unit value: $2.47

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians, was $2.47 as of February 28, 1979. ■

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of February 13, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

ASHLAND-BAYFIELD-IRON

Oujiri, John C, 2101 Beaser Ave, Ashland 54806 (1949, Regular, Family Physician)

Van Pernis, Paul, 2101 Beaser Ave, Ashland 54806 (1948, Regular, Family Physician)

DANE

Benton, George D, 1912 Atwood Ave, Madison 53704 (1940, Regular, Family Physician, Certified)

Hanson, Jerome T, 2721 Mason St, Madison 53705 (1947, Resident, Internal Medicine/Gastroenterology, Certified-IM)

Kark, Richard A, 5001 Monona Dr, Monona 53716 (1947, Regular, Family Physician, Certified)

Larkin, Edwin R, 5184 W River Rd, Waunakee 53597 (1936, Regular, Public Health/Physical Medicine and Rehabilitation, Certified-PM)

Mitchell, Torrey L, 1912 Atwood Ave, Madison 53704 (1942, Regular, Pediatrics/Hematology, Certified-PD)

Thomas, Stephen C, 5001 Monona Dr, Madison 53716 (1948, Regular, Family Physician, Certified)

MARATHON

Davila, Julio C, Wausau Hospital North, Maple Hill, Wausau 54401 (1921, Regular, Thoracic Surgery/Cardiovascular Surgery, Certified-GS)

Stelle, Robert E, Wausau Hospital North, Maple Hill, Wausau 54401 (1930, Regular, Family Physician, Certified)

MILWAUKEE

Bernhard, Victor M, 8700 W Wisconsin Ave, Milwaukee 53226 (1927, Regular, General Surgery, Certified)

Fehrer, Michael R, 7826 W Wright St, Wauwatosa 53213 (1946, Resident, Internal Medicine)

Gennrich, Joan M, 1636 Fairfield Court, Glendale 53208 (1937, Regular, Emergency Medicine/Family Physician)

Nimmagadda, H B, 2388 N Lake Dr, Milwaukee 53211 (1940, Regular, Ophthalmology/General Practice, Certified-OPH)

Parker, Wayman, 2003 W Capitol Dr, Milwaukee 53206 (1944, Regular, Obstetrics and Gynecology)

Sennett, Jordan A, 1218 W Kilbourn Ave, Milwaukee 53233 (1945, Regular, Internal Medicine/Endocrinology, Certified-IM)

RACINE

Crast, Frank W, 5625 Washington Ave, Racine 53406 (1945, Regular, Pediatrics/Infectious Diseases, Certified-PD)

ROCK

P Ramadasan, 1748 Oakleaf Dr, South Beloit, IL 61080 (1938, Regular, Emergency Medicine/General Surgery)

WAUKESHA

Schuler, William E, 434 Madison St, Waukesha 53186 (1949, Resident, Family Physician)

Vollrath, Victoria A, 434 Madison St, Waukesha 53186 (1949, Resident, Family Physician)

WINNEBAGO

MacDonald II, C C, 411 Lincoln, Neenah 54956 (1947, Regular, Pediatrics, Certified)

WOOD

Frens, David B, 1000 N Oak Ave, Marshfield 54449 (1944, Regular, Pediatrics/Neurology, Certified-PD)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Crumpacker, Margaret, Hong Kong, to 2203 Linden Dr., Valparaiso, IN 46383

GREEN LAKE-WAUSHARA

Raval, Mayuri P, Berlin, to 79 Gwen Lake Blvd, Lake City, FL 32055

Raval, Pinakin M, Berlin, to 79 Gwen Lake Blvd, Lake City, FL 32055

KENOSHA

Kleinpell, Walter C, Kenosha, to 1601 Pelican Point Dr, Sarasota, FL 33581

Ruehlman, David D, Mountain View, CA, to 1220 Tasman Dr, Sunnyvale, CA 94086

PIERCE-ST CROIX

Larson, E Arthur, New Richmond, to PO Box 6013, Tallahassee, FL 32301

DEATHS

Henschel, Ernest O, Milwaukee County, Feb 1, 1979

Mason, Elwood W, Milwaukee County, Feb 4, 1979 ■

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Paul S Treuhaft, MD,* Marshfield, is the new president of the Wood County Medical Society; vice-president is Charles F Wood, MD,* Wisconsin Rapids, and Homer H Russ, MD,* Marshfield, is secretary-treasurer. Delegates to the State Medical Society are: Richard H Ulmer, MD,* Marshfield, Raymond L Hansen, MD,* Marshfield, Michael P Mehr, MD,* Marshfield, and John E Thompson, MD,* Nekoosa. Alternate delegates are MDs Wilbur J Boulet,* Marshfield, William J Maurer,* Marshfield, John P. Milbauer,* Marshfield, and Charles C Sorensen,* Wisconsin Rapids. Named to the Board of Censors and Peer were Charles C Sorensen, MD* and William M Toyama, MD,* Marshfield. Elections were held at the December 7, 1978 meeting in Wisconsin Rapids. SMS President Jules D Levin, MD* addressed the 81 physicians and guests, speaking on matters of interest to medicine in general and to the State Medical Society affairs in particular.

Maruthi Kantamneni, MD, Platteville, recently joined the Cuba City Doctors Clinic, SC. Doctor Kantamneni attended the Jamaica Hospital in New York and received his membership to the American Board of Internal Medicine. He recently was submitted as a diplomate in the *Directory of Medical Specialists* throughout the nation.

George R Barry, MD,* internist at The Monroe Clinic, recently was named president of the Medical Staff at St Clare Hospital for the second time since coming to Monroe 30 years ago.

Keith Jantz, MD, Madison, recently became associated with the Jackson Clinic. Doctor Jantz graduated from the University of Kansas Medical School and completed his internship and residency training in internal medicine at Baptist Memorial Hospital, Memphis.

Vinoo Cameron, MD, Madison, will be joining N J Hollero, MD,* Iola, at the Iola Clinic in June. Doctor Cameron is finishing his two-year surgical-pathology residency at Madison General Hospital. He received his medical training in India and completed residency training in India and England. He has been working part-time at the Clinic since February.

David N Goldstein, MD,* Kenosha, who retired from active practice late in 1978, has embarked on a new project, the establishment of a special jogging exercise area, called a PAR-Course in one of the Kenosha parks. It is part of an overall community program to combat heart disease, which Doctor Goldstein calls "one of the best public health measures left to tackle" in Kenosha.

John E Bottsford Jr, MD, recently became associated with the West Side Clinic in Green Bay. Doctor Bottsford, a general and peripheral vascular surgeon, is a graduate of Loma Linda University, Calif. He served his internship at Kettering Memorial Hospital, Dayton, Ohio, and completed his residency training at White Memorial Medical Center, Los Angeles, and Spartanburg General Hospital, Spartanburg, SC. He received a vascular fellowship from Max Gaspar and Associates, Long Beach, Calif.

Larry L Hanley, MD,* former director of the Eau Claire Family Practice Residency Program, has joined the medical staff of St Joseph's Hospital, Chippewa Falls. He graduated from Indiana University School of Medicine in 1960. He previously had practiced medicine in Whitehall, Black River Falls, and at the Putnam Heights Clinic, Eau Claire. In 1975 he was named director of the Eau Claire Family Practice Residency Program.

Walter T Becker, MD,* medical director of the Wausau Medical Center, recently retired from his position. Doctor Becker served in World War II from 1941 to 1946 and came to Wausau where he practiced general surgery until joining the Wausau Medical Center in 1972. He has served as medical director of the Center since 1972, and has been instrumental in its growth and in the development of the medical facility.

Joseph B Durst, MD,* LaCrosse, an obstetrician-gynecologist at Skemp-Grandview Clinic, recently was elected chairman of the Wisconsin section of the American College of Obstetrics-Gynecology and will serve a three-year term. Doctor Durst is a graduate of Marquette University School of Medicine, Milwaukee.

Jack C Westman, MD,* professor of psychiatry at the University of Wisconsin Medical School-Madison, recently was installed as president of the American Association of Psychiatric Services for Children. Doctor Westman has been associated with the University of Wisconsin Medical School since 1965. In 1975 the Mental Health Association of Wisconsin cited him for "Special Services to Children" and in 1977 as the "Citizen of the Year."

FIFTY-YEAR CLUB MEMBERS—1978. By special request the above picture of the Fifty-Year Club members who attended the 1978 Annual Meeting Awards Dinner is being published to duly recognize this elite group. They are (left to right): Front row: Alphonsus M Rauch, MD,* Lake Geneva; James J King, MD,* Milwaukee; R W Farnsworth, MD,* Janesville; Hubert J Farrell, MD,* Milwaukee; Sylvester E Coffey, MD,* Wauwatosa. Back row: John D Wilkinson, MD,* Oconomowoc; Maurice A Hardgrove, MD,* Milwaukee; Joseph J Grimm, MD,* South Milwaukee; Robert P Montgomery, MD,* Milwaukee; Raymond R Richards, MD,* Eau Claire, Raymond M Baldwin, MD,* Beloit. The WMJ apologizes for not having published this picture sooner. ■

CONTRIBUTIONS CES FOUNDATION FEBRUARY 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1979.

Unrestricted

David N Goldstein, MD; SMS Members; George W Arndt, MD; Russell F Lewis, MD; Cornelius Sullivan, MD; Rowland Leiby, MD—*Voluntary Contributions*

Restricted

Wausau Family Practice Clinic—*Medical Student Summer Externship Program*
AH Robins—*Guest Speaker Fund*
William Westley Jr, MD; Arthur C Taylor, MD; James D Warrick, MD—*Museum of Medical Progress*
Mrs Irwin J Bruhn; Mrs Roland Thurow; Membership Dues—*Aesculapian Society*

Memorials

Marion P Crownhart—*CO Vingom, MD (Crownhart Memorial Fund)*
Dr-Mrs SD Austin & Family—*Mr Norbert H Jansen (Brown County Loan Fund)*
State Medical Society—*Marian Lewis, MD; Forrest E Zantow, MD; EO Henschel MD; Elwood Mason, MD*
Dr-Mrs EJ Nordby; Wisconsin Physicians Service; Earl R Thayer—*CO Vingom, MD*
Earl R Thayer—*Elwood Mason, MD*

Milton Finn, MD, Superior, was honored March 7 by the Douglas County Medical Society for his 35 years of continuous membership. He was presented a plaque. Because he has reduced his practice in a retirement process, Doctor Finn, early in 1979, was elected an Associate Member by his county society and the State Medical Society of Wisconsin. As an Associate Member his dues are waived, but he continues to receive membership benefits. Doctor Finn, who graduated from the University of Wisconsin Medical School, Madison, in 1938, received his Wisconsin license in 1941 and began practicing in 1942. In 1951 he became a member of the directing board of the State Medical Society's health insurance plan—Wisconsin Physicians Service—and has remained on the board to the present time, although WPS now is a separate corporation.

George T Bryan, MD* of the Wisconsin Clinical Cancer Center in Madison attended a World Health Organization meeting in Lyon, France, March 21-27, to help prepare a monograph on the "Evaluation of Artificial Sweeteners." ■

Publications

Alternative Health Care Delivery Systems: "The HMO Concept" was developed to enhance the knowledge of AMA membership regarding Health Maintenance Organizations. The brochure discusses the HMO concept, its history, legislative status, modes of delivery, cost effectiveness and quality of care. Federal qualification by the Office of Health Maintenance Organizations is discussed as well as the federal grant and loan program for qualified Health Maintenance Organizations. The state certification process of Health Maintenance Organizations also is discussed. The brochure (MP 12) has: single copies free; 2-10 copies, 30¢ each; 11 or more copies, 20¢ each. Single copies may be obtained by contacting the AMA Department of Professional Review, 535 North Dearborn St, Chicago, Ill 60610, and bulk copies can be ordered from: AMA Order Handling, PO Box 821, Monroe, Wis 53566.

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

St Catherine's Hospital, Kenosha, recently elected James A Heck, MD,* president of the medical staff for 1979. Doctor Heck graduated from the University of Illinois Medical School, Chicago, and has practiced medicine in Kenosha since 1964. Other medical staff officers are MDs Roman Bilak,* past president; Lee H Huberty,* president-elect; and John J Sanson,* secretary. Members of the executive committee are MDs Blair Bonell;* Michael J Bode;* and Ernesto Buencamino.* Chairman of the surgical committee is A Yale Gerol, MD,* and the medical committee chairman is D Boyd Horsley, MD.*

The Skemp-Grandview Clinic, LaCrosse, has announced that Joseph B Durst, MD* is the new president. Doctor Durst, a member of the obstetrics-gynecology department, also is chairman of the ad hoc committee on merger of Skemp-Grandview and LaCrosse clinics. In addition, Doctor Durst is chairman of the Wisconsin Section of the American College of Obstetrics-Gynecology.

St Marys Hospital Medical Center, Madison, recently elected Stephen Dudiak, MD,* as its chief-of-staff. He has served as chairman of the Department of Radiology for several years. Elected to serve with Doctor Dudiak were MDs Gerald Derus,* chief-elect; Robert Emslie, secretary-treasurer; and Thomas Kaske,* representative to the Dane County Medical Society.

Mercy Hospital, Beloit, recently elected Eugene H Betlach, MD,* as its chief-of-staff. Doctor Betlach, a radiologist, has been associated with the medical staff of the hospital since 1953. Other officers elected are MDs Nicholas G Papadakes,* a member of the medical staff since 1968, who is president of the staff; Rocco J Vitacca, is president-elect; and Thomas McCall* is secretary-treasurer.

Gundersen Clinic, Ltd, LaCrosse, has elected Sigurd B Gundersen, Jr, MD,* president of the Clinic for the year 1979. Doctor Gundersen succeeds Kermit L Newcomer, MD,* who served as president from 1976 to 1978. Officers serving with Doctor Gundersen are MDs William Kisken,* executive vice-president; Kermit L Newcomer,* vice-president; and John Swingle,* secretary-treasurer. New board members are David E Goodnough, MD* and Gregory Mahairas, MD.* Other board members are MDs Adolf Gundersen,* Cornelius Natoli,* and William Morgan.*

Elmbrook Memorial Hospital, Brookfield, recently named new members to the board and to the executive committee of the hospital. The three new members of the executive committee are MDs Joseph T Maier, Brookfield; Walter R Schwartz,* Wauwatosa; and J D Rienstra, Elm Grove. Five members continuing their terms on the executive committee are MDs George Korkos,* Elm Grove, chief-of-staff; Robert Pavlic,* Brookfield, vice-chief-of-staff; Lawrence Burkert,* Elm Grove, secretary-treasurer; Philip Guzzetta,* Elm Grove, chairman of the Department of Surgery; and Terrence Hart,* Brookfield, chairman of the Department of Medicine.

Edgewood College, Madison, will begin accepting applications for its new Nursing major immediately with the four-year program leading to a Bachelor of Science degree beginning next September. Sister Alice O'Rourke, Edgewood's president, announced in January that the College's new baccalaureate program for nurses had been officially approved by the Wisconsin State Board of Nursing. Edgewood recently hired a nursing administrator, Linda A Simunek, RN, PhD, former dean of the college of nursing at Lewis University, to head its new department. Last summer Edgewood and Madison General Hospital reached an affiliation agreement whereby the college will use facilities at MGH's school of nursing as Edgewood's baccalaureate program develops. In line with this agreement, Madison General Hospital will now begin to phase out its 75-year-old diploma-granting school of nursing.

The Top US Air Force Medical Recruiter in the nation is M/Sgt Raymond F Wolf of Greenfield, Wisconsin. His selection was made by Brig Gen William P Acker, US Air Force Recruiting Service Commander. Sgt Wolf has been assigned to the 3555th USAF Recruiting Squadron, headquartered in Milwaukee, Wisconsin for more than 11 years. Last year, he achieved 100 percent of his requirement in both the Air Force Physician and Health Professions Scholarship programs. In addition, he achieved an unprecedented 200 percent in the Biomedical Corps recruitment effort. M/Sgt Wolf is responsible for health professions recruiting throughout most of Wisconsin and the Upper Penninsula of Michigan. His home office is located in the Wauwatosa Professional Building, 2457 North Mayfair Road, Wauwatosa, Wisconsin. ■

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Medical Yellow Pages

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Physicians Exchange

WANTED: INTERNIST INterested in cardiology for part-time work (15-35 hours/week) at the Bureau of Social Security Insurance, 310 Price Place, Madison, Wis 53705. If interested please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel: 608/266-1989. 2-5/79

WISCONSIN, SHEBOYGAN — career oriented ED physician needed to help train and maintain hospital-based paramedic program. Flexible schedule with 20 days off each month. Superb recreational, educational, and cultural opportunities for physician and family in this city on the shores of Lake Michigan and adjacent to Milwaukee, Wis. 250-bed hospital with 10,000 patient visits per year. Remuneration: $63,300. Call or write Dr John Hron, ER Director, Sheboygan Memorial Hospital, Sheboygan, Wis 414/457-5033 or 414/377-9147. 2-4/79*

THREE YOUNG FAMILY PHYsicians need fourth man in college community of 80,000 in Southeastern Wisconsin. Two general hospitals with a total of 700 beds. Salary and fringe benefits first year—partnership thereafter. Contact Dept. 421 in care of the journal. 9tfn/74

WANTED: TWO FAMILY PHYsicians preferably ABFP for association with the Family Medical Center, Sheboygan, Wisconsin. Please call or write: Martin A Rammer, MD, 1930 N 8th St, Sheboygan, Wis 53081; phone 414-457-5016. 5tfn/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

MEDICAL DIRECTOR/EMERgency department. Immediate opening for qualified physician to assume position of Medical Director for the Emergency Department of progressive 460-bed hospital located in suburban community, eight miles from downtown Minneapolis. Primary responsibility and authority for professional supervision of active Emergency Department with emphasis on high quality patient care. Complete specialty back up, over 400 physicians on staff. Approximately 43,000 emergency department visits annually. Spacious new facility. Excellent salary and benefits through professional corporation. Strong individual with residency training in emergency medicine or surgery preferred, or other specialty with strong background and interest in emergency medicine. Forward curriculum vitae to Mr Terry Finzen, Associate Administrator, Methodist Hospital, 6500 Excelsior Boulevard, St Louis Park, Minn 55426, or call collect 612/932-5015. 3-4/79

WISCONSIN, SHAWANO—SUperb opportunity for primary care physician to work in an ER and enjoy the recreation of northern Wisconsin. Only 30 miles from the Green Bay Packers. 100-bed community hospital with 8,500 annual ER visits. Remuneration: $66,240 for 10 days each month. Send resume or call Dr John Kirkpatrick, ER Director, Shawano Community Hospital, Shawano, Wis. 715/526-2111. 2-4/79*

FAMILY PHYSICIAN — O/B experience. Emergency Room Physician—July, August 1979. Opportunity for one of each in northern Wisconsin resort town of Eagle River. New clinic facility attached to hospital. Drawing area includes all of Vilas County, parts of Oneida, Forest, plus a large tourist and retirement population. If interested, contact: Charles E Reevs, Admin, Eagle River Memorial Hospital, Eagle River, Wis 54521. Tel: 715/479-7411. 1tfn/79

EMERGENCY ROOM PHYSIcian wanted to join 4-man group beginning 7/79. Racine, Wis. CV to Associated ER Physicians, Box 172, Caledonia, Wis 53108. Tel: 414/835-4889. 3-4/79

WANTED: BOARD CERTIFIED or Board eligible internist, general or with subspecialty. University community of 40,000 with drawing area of 100,000. One hour from ocean, mountains, or desert. Six months guaranteed income. JCAH approved hospital, licensed for 195 beds. Resume: Box 1506, Loma Linda, Ca 92354. 3-4/79

PUTNAM HEIGHTS CLINIC, SC (3 GPs and 1 PA), 2125 Heights Dr, Eau Claire, Wis, want 1979 graduate of Family Practice Residency to start employment July or August 1979. Must be interested in teaching, both at our office and local Family Practice Residency. Call collect 715/832-3401. GG Giffen, MD. 3-4/79

PHYSICIANS—WE SAVE YOU TIME AND KEEP YOUR CAREER LOCATION SEARCH COMPLETELY CONFIDENTIAL

We're all medical professionals ourselves so we recognize outstanding opportunities. Tell us your geographic and position choices and salary expectations. We'll match them with the career opportunities we have available in Wisconsin as well as nationwide.

Contact Donna Herschleb, RN

HORNER MEDICAL PLACEMENTS

802 W Broadway, Suite L-6M
Madison, WI 53713
Tel: 608/222-1616

Licensed Employment Agency

1tfn/79

Physicians Exchange

continued

PHYSICIANS — IMMEDIATE openings nationwide in the following specialties: Internal Medicine, Radiology, Pediatrics, Anesthesiology, Physical Medicine, Orthopedics, Psychiatry, Ophthalmology, General Practice, Emergency Medicine, Gynecology, General Surgery, and many more. Call or write DR PERSONNEL outlining your location and salary. DR PERSONNEL, a nationwide professional personnel service for the health profession, 2040 W Wisconsin Ave, Milwaukee, Wis 53233. Tel: 414/933-7788. 1tfn/78

WANTED: PSYCHIATRIST INterested in part-time work (15-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wis 53705. If interested, please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel: 608/266-1989. 2-5/79

WANTED: FAMILY OR GENeral practitioner to serve East Central Wisconsin small college town of 7,000, close proximity to community hospital with up-to-date facilities. Guaranteed base income with opportunity for partnership. Call or write for details to R S Pelton, MD, 315 Mt Zion Dr, Ripon, Wis 54971. Tel: 414/748-2875. 10tfn/78

CORRECTIONAL MEDICINE

Challenging opportunities in primary health care—available in a most efficiently designed prison health care system—excellent climate—competitive salaries.

Employment available in the Spring of 1979 (April-June). 93 positions available for:

- Physicians
- Dentists
- Psychiatrists
- Physician's Assistants
- Nurses
- Armed Forces Trained Paramedics
- Dental Technicians
- Psychologists
- Health Administrators

Must be eligible for Oklahoma Licensure.

Contact:

Armond H Start, MD, MPH
Medical Director
Oklahoma Dept of Corrections
3400 North Eastern
Oklahoma City, Oklahoma
73111

2-4/79

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

PROGRAM/MEDICAL DIRECtor, Physician Assistant Program. Assume leadership of a state-supported, accredited BS degree program. Responsibilities include administration and continuing development of the program. Applicant must be a physician licensed or qualified for licensure in the State of Wisconsin and, preferably board certified or board eligible in a primary care area. Detailed position description available. Contact John L Peterson, Dean, School of Allied Health Professions, University of Wisconsin-Madison, 610 N Walnut St, Madison, WI 53706. Tel: 608/263-6800. EOE. 3-4/79

GENERAL INTERNIST AND family practitioner needed by 9-physician multispecialty group. Clinic is near hospitals, industries, schools, housing. Excellent fringe benefits, profit sharing; salary negotiable. Send curriculum vitae to: George V Murphy, MD, 100 15th Ave, South Milwaukee, Wis 53172. 4/79

GP FOR SMALL SOUTH DAKOta community, 20-bed modern hospital, solo practice, good potential income. Call administrator, Bowdle Hospital, tel: 605/285-6146. 4/79

MULTISPECIALTY GROUP OF 29 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

WANTED: ORTHOPEDIST INterested in part-time work (15-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wis 53705. If interested, please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel. 608/266-1989. 2-5/79

WANTED: GENERAL SURgeon and family practice physician to join a group of nine family practitioners, one general internist in a rural community in northwestern Wisconsin. For additional information, contact Lloyd Cotts, MD, Rice Lake, Wis. Tel: 715/234-9031. 2-4/79

FAMILY PHYSICIAN: WAUSAU to join three board certified ABFP physicians. New medical office opened March 1978 and new hospital to open in 1979. Contact: R E Cadwell, MD, 212 Sturgeon Eddy Rd, Wausau, Wis 54401. Tel: 715-842-0491. 10tfn/78

THE WAUSAU MEDICAL CENter, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology
- Dermatology
- Family Practice for satellite clinic
- Neurology
- Otolaryngology
- Thoracic Surgery with Peripheral-Vascular Surgery

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, write John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 3tfn/79

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

BOARD CERTIFIED DIAGNOStic radiologist available to provide consultation service: 1) to physicians in an office setting or at small community hospitals in Wisconsin: 2) for other radiologists in small solo practices who desire "Locum Tenens" coverage for CME purposes for up to one week. Contact Dept 465 in care of the Journal. 4-5/79

FAMILY PRACTITIONERS OR internist and pediatrician for satellite primary care office located in West Allis, Wis. Call shared by other members of 34-physician multispecialty group. For further information contact E Daun, Administrator, Northpoint Medical Group, 2388 N Lake Dr, Milwaukee, Wis 53211. Tel: 414/289-3918. 4tfn/79

WANTED MEDICAL SPECIALties — small town between Milwaukee and Chicago serving a shopping area population of 50,000. Has 140-bed hospital, 14 GPs, 3 OB/GYNs, 1 ophthalmologist and 1 orthopedic surgeon. Custom built office space in superbly located new building. For full details contact Arthur L McCourt, 148 S Pine St, Burlington, Wis 53105. Tel: 414/763-7697. 4-9/79

Physicians Exchange

continued

EMERGENCY PHYSICIAN WANTED to join established 4-man group at Madison General Hospital in Madison, Wisconsin, the State Capitol and home of the University of Wisconsin. Great place to live. Salary plus benefits. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 3tf/79

HEALTH SERVICE PHYSICIAN-GP, FP, or internist to share outpatient care and treatment for 6000+ students on the attractive Midwest campus of South Dakota State University. Exceptional staff and facilities for student care. Excellent hours. Free weekends. Flexible contract: 9-12 months. Must be interested in providing general primary medical care for college-age population. Very competitive salary with excellent fringe benefits. Some experience in adolescent or college practice is beneficial but not required. Applications accepted through June 1, 1979 or until suitable applicant is found. Send resumé and two references or call collect James O Pederson, Dean of Student Services, South Dakota State University, Brookings, SD, 57007, 605/688-4121. The University is an Affirmative Action/Equal Opportunity Employer (Female/Male) 4/79

GROW INTO GOING PRACTICE as a full partner and gradually take over. Established solo practitioner with prosperous practice in lovely, well-populated area in Southern Wisconsin, looking for a "take-over" man in Family Practice or Internal Medicine. Modern hospital nearby will assist with full range of support. Also, two neighboring communities with medical suites but no physicians—hospital will help establish selected physicians. Call Consult-Wisconsin. 305/920-9000, ext 195 (collect) or send CV to Consult, Suite 211, 1909 Harrison St, Hollywood, Florida 33022. p4/79

Allied Health Services

PHYSICIAN ASSISTANT RECENT graduate of Northeastern University (Tufts affiliated) program, Boston, seeks employment in a small-town, rural, family practice setting. BS biology and six years ER experience prior to PA training. Claude Erickson, 2261 Lois Dr, New Brighton, Minn 55112. Tel: 612/784-5894. p4/79

Recreational

Advertisers of recreational equipment and services are invited to place their messages in this classification.

Medical Facilities

MEDICAL CLINIC SPACE available. Janesville Road and Pioneer Drive, Muskego. 2,500 sq ft on ground floor. Modern, move-in condition. Please contact: Roger Bothe, John Herschede & Associates, Inc. Tel: 414/933-0585. 7tfn/78

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOND DU LAC FACILITY. Complete medical practice suite available soon. Suitable for group practice of five or six, or a pair and three. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

FOR SALE: PHYSICIAN AND surgeon deceased. Lovely lannon stone home and two doctor offices with x-ray, consultation drug room, large waiting room and business office, and private offices in A condition with two-car garage. Call 414/863-2106. g2tfn/79

Practices Available

AVAILABLE: MARCH 1979 ESTABLISHED medical practice and equipped office and records. Suitable for solo or group. Will lease. South side of Milwaukee. Tel: 414/352-9736. 1tfn/79

Announcements

The National Hemophilia Foundation is now accepting applications for its 1980 Judith Graham Pool Research Fellowships. Awards are granted for studies in clinical and/or basic science which are aimed at furthering understanding, or improving management, of the hemophilias and von Willebrand's Disease. Proposed research may concern biochemical, genetic, or may focus on rehabilitation, therapeutic modalities, or social features of the hemophilias. Information and application forms are available from The National Hemophilia Foundation, 25 West 39th St, New York, NY 10018. Deadline for application is October 1, 1979. Awards will be announced by December 31, 1979.

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Smith Kline & French 33
Dyazide®
20-20 Direct 45
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United States Air Force 67
Upjohn Co, The 22,23,24
Motrin®
Warner/Chilcott 9
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IN- "WATS"
toll-free number
1-800-362-9080
to reach staff at
SMS headquarters in Madison

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with .others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1979 Wisconsin

May 3-5: Wisconsin Chapter: American Academy of Pediatrics, Pioneer Inn, Oshkosh, Wis 54901.

May 10-12: State Medical Society of Wisconsin Annual Meeting. MECCA and Marc Plaza, Milwaukee.

May 10: Wisconsin Academy of Family Physicians Board Meeting, Marc Plaza, Milwaukee.

May 10: Wisconsin Chapter, American College of Surgeons Board Meeting, Marc Plaza, Milwaukee.

May 11: Wisconsin Society for Preventive Medicine Business Meeting, MECCA, Milwaukee.

May 11: Wisconsin Society of Radiation Oncology Business Meeting, MECCA, Milwaukee.

COUNSELING—THE ART

May 7-9, 1979

Valley Inn—Neenah

Annual Conference of the Wisconsin Association on Alcoholism & Other Drug Abuse, Inc.

Current intervention and counseling strategies; pertinent to administrators, counselors and concerned others, both in and out of the alcohol and drug problems field.

Info: Don Johnson, WAAODA, 333 West Mifflin St, Madison, Wis 53703. Tel: 608/257-7970

May 11: Wisconsin Society of Plastic Surgeons Dinner, Brynwood Country Club, Milwaukee.

May 11: Wisconsin Orthopaedic Society Dinner, University Club, Milwaukee.

May 12: Wisconsin Otolaryngological Society Business Meeting, MECCA, Milwaukee.

May 12: Wisconsin Society of Physical Medicine and Rehabilitation Business Meeting, MECCA, Milwaukee.

May 12: Wisconsin Surgical Society Business Meeting, MECCA, Milwaukee; and Dinner, Milwaukee Athletic Club.

May 12: Wisconsin Allergy Society Business Meeting, MECCA, Milwaukee.

May 12: Wisconsin Chapter, American College of Emergency Physicians Business Meeting, MECCA, Milwaukee.

May 12: Wisconsin Society of Internal Medicine Dinner, Milwaukee Athletic Club, Milwaukee.

May 12: Wisconsin Neurological Society Business Meeting, MECCA, Milwaukee.

May 12: Wisconsin Orthopaedic Society Business Meeting, MECCA, Milwaukee.

May 12: Wisconsin Radiological Society Business Meeting, MECCA, Milwaukee.

May 18-19: *Strabismus Symposium*-Special diagnostic techniques during the Mid-West Orthoptic Meeting. Concourse Hotel, Madison. 13 hours Category I credit. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706.

May 18-23: American Holistic Medical Association Annual Meeting, at University of Wisconsin, LaCrosse. Cosponsored by The American Society of Contemporary Medicine and Surgery. Forty hours of Category I CME credit. Info: AHMA, Route 2, Welsh Coulee, LaCrosse 54601.

May 18-24: *Exploring The Dimensions of Scientific Medicine,* American Holistic Medical Association International Conference, University of Wisconsin at LaCrosse. Info: AHMA, Rt 2, Welsh Coulee, LaCrosse 54601. Tel: 608/786-0611.

June 1-2: *Medical and Surgical Corneal Disease.* North Central Regional Meeting, Eye Bank Association. Concourse Hotel, Madison. Category I credit available. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706.

June 1-2: Wisconsin Neurological Society, Heidel House, Green Lake.

June 7-8: Midwest Head and Neck Cancer Conference, State of the Art Program, Concourse Hotel, Madison. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

June 8-9: Wisconsin Psychiatric Association Annual Scientific Program and Membership Meeting, Marc Plaza, Milwaukee. Nathan Kline, MD, Rockland, NY, will be the keynote speaker reviewing psychopharmacology — its past, present, and future.

June 11-15: The Writing Workshop for MDs. Holiday Acres Resort, Rhinelander. Sponsored by UW-Exten-

1979 Wisconsin

continued

sion. Info: Joe Eisele, Continuing Education Agent, UW-Extension Box 695, 1002 Coon St, Rhinelander, Wis 54501. Tel: 715/362-4093.

June 22-24: 31st Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians. The Abbey Resort, Fontana, Wis. 15 hours of CME and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove 53122.

July 27-28: Wisconsin Society of Obstetrics and Gynecology, Fox Hills Resort, Mishicot.

July 27-29: *Coronary Disease, Exercise Testing, and Cardiac Rehabilitation,* Playboy Club, Lake Geneva. Info: Director of CME, Dept 9, International Medical Education Corp, 64 Inverness Drive East, Englewood, CO 80112. Tel: toll free 1-800/525-8646.

July 29-Aug 1: The Second Annual *Nuclear Cardiology for the Practicing Physician* at Playboy Club Resort, Lake Geneva, Wis. Info: Dr Jagmeet S Soin, Division of Nuclear Medicine, The Milwaukee County Medical Complex/The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5968.

Sep: Wisconsin Neurosurgical Society (day and location, not yet set).

American Holistic Medical Association

International Conference

EXPLORING THE DIMENSIONS OF SCIENTIFIC MEDICINE

May 18-24, 1979

University of Wisconsin at LaCrosse

Over 50 presentations plus in-depth experimental workshops related to stress control and High Level Wellness. Special Medical Deans' Panel—5 Deans will discuss current extent of Science in Medicine. 444 hours of Category 1, CME. CO-SPONSORS: St Francis Hospital—LaCrosse; American Society of Contemporary Medicine and Surgery; Biogenic Institutes of America.

Contact: AHMA, Rt 2, Welsh Coulee, La Crosse, WI 54601. Tel: 608/786-0611
3-4/79

1979 MIDWEST HEAD AND NECK CANCER SEMINAR

June 7 & 8, 1979, University of Wisconsin

Clinical Science Center, Madison, Wisconsin

Thursday, June 7

am

9:00 Welcome, James H Brandenburg, MD

Carcinoma of the Oral Cavity and Pharynx: Moderator, John K Scott, MD

9:05 *Selection of Patients for Primary Radiation Therapy,* by Stanley V Hoover, MD

9:35 *Management of Dental Problems Associated with Radiotherapy,* by Adrian D Duszynski, DDS

9:50 *Maxillo-facial Prosthetic Reconstruction* by Paul J Correll, DDS

10:25 *Reconstruction of the Oral Cavity,* by Emanuel M Skolnick, MD

10:45 *Management of Recurrent Disease,* by George A Sisson, MD

11:25 *Reconstruction of the Hypopharynx Using a Tongue Flap,* by John M Lore, MD

11:45 Panel—Questions and Answers

pm

Primary Neck Tumors: Moderator, John M Mills, MD

1:30 *Pathology of Lymphomas,* by Gholam R Hafez, MD

1:45 *Chemotherapy Management of Lymphomas,* by Thomas E Davis, MD

2:15 *Radiation Therapy Management of Lymphomas,* by Robert Edland, MD

2:35 *Surgical Management of Neck Metastases,* by James H Brandenburg, MD

3:10 *Pathology of Thyroid Tumors,* by Kennedy Gilchrist, MD

3:25 *Surgery of the Thyroid Gland—Indications and Technique,* by John M Lore, MD

4:00 Panel—Questions and Answers

6:30 Reception—Concourse Hotel

Friday, June 8

am

Carcinoma of the Larynx: Moderator, John E Clemons, MD

9:00 *Pathology—Laryngeal Serial Sections,* by Kennedy Gilchrist, MD

9:20 *Partial Laryngectomy Surgery,* by Emanuel M Skolnick, MD

9:40 *Radiation Therapy for Early Carcinoma of the Larynx,* by Stanley V Hoover, MD

10:40 *Creation of a Neoglottis,* by George A Sisson, MD

11:00 *Combined Modalities for Advanced Stages of Disease,* by Stanley V Hoover, MD

11:20 Panel—Questions and Answers

pm

Salivary Gland Tumors: Moderator, James H Brandenburg, MD

1:30 *Pathology of Salivary Gland Tumors,* by Gholam R Hafez, MD

1:50 *Surgical Management of Malignant Salivary Gland Tumors,* by Emanuel M Skolnick, MD

2:50 *Management of the VII Nerve in Parotid Surgery,* by John M Lore, MD

3:10 *Radiation Therapy in the Treatment of Malignant Salivary Gland Tumors,* by Stanley V Hoover, MD

4:20 Adjourn

This program meets the criteria for 11 credit hours in Category I of the PRA of the AMA. Info: University of Wisconsin-Extension, 610 N Walnut St, Madison, Wisconsin 53706. Registration deadline May 18, 1979.

18th ANNUAL MEDICAL-LEGAL-INDUSTRIAL SYMPOSIUM

Friday, November 9, 1979

Hotel Pfister/7th Floor
Milwaukee, Wisconsin

Cancer and Industry

Program

am

8:00 Registration

9:00 Welcome / Daniel A Kane, Executive Vice-President, Mount Sinai Medical Center

9:05 Introduction/Sidney K Wynn, MD, Symposium Chairman, Mount Sinai Medical Center

9:10 The Politics of Cancer/ Samuel S Epstein, MD, Professor of Occupation and Environmental Medicine, School of Public Health, University of Illinois

10:35 Cancer of the Lung as Related to Industry/ Norbert Enzer, MD

11:05 Surveillance Studies in Industry/Sidney Shindell, MD,LLB, Professor and Chairman Department of Preventive Medicine, MCOW

11:30 Metals Intoxication as Related to Cancer/Carl Zenz, MD, School of Occupational Medicine

pm

1:30 Role of RN in Early Detection of Cancer/ Judy Hayes Bernhardt, Associate Professor of Occupational Health Nursing, School of Nursing, University of Wisconsin-Milwaukee

1:50 Compensability of Occupational Cancer/Attorneys Leonard S Zubrensky and John H Jones; and Hugh Russell, Workers Compensation Division

2:50 Question and Answer Period

Further information contact Mount Sinai Medical Center, Medical Center Relations, PO Box 342, Milwaukee, Wisconsin 53201.

1979 Wisconsin

continued

Sept 8: Wisconsin Allergy Society Annual Meeting, at Pioneer Inn, Oshkosh. Topics: Pulmonary Function/ Stinging Insect Allergies. Further details will be announced in a future issue.

Sept 13-15: Wisconsin Society of Internal Medicine, Playboy Club, Lake Geneva.

Sept 14-16: Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Sept 19: One-Day Seminar for Family Physicians, St Vincent Hospital, Green Bay

Oct 17: One-Day Seminar for Family Physicians, Bellin Memorial Hospital, Green Bay.

Nov 9: 18th *Annual Medical-Legal-Industrial Symposium: Cancer and Industry*, Pfister Hotel, Milwaukee. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee 53201. Tel: 414/289-8200.

Nov 14: One-Day Seminar for Family Physicians, St Vincent Hospital, Green Bay.

1979 Neighboring

May 4-6: Michigan State Medical Society, Kalamazoo Center Inn, Kalamazoo. Info: W F Tryloff, 120 W Saginaw, East Lansing, MI 48823.

May 6-9: Illinois State Medical Society, Palmer House, Chicago. Info: R N White, 55 E Monroe St, Chicago, IL 60603.

May 11: Thirty-second Annual Meeting, American Heart Association,

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1979-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1979 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

April 30-May 13, 1979

Myocardial Perfusion Imaging with 201 Thallium, with Paul J Cannon, MD, Professor of Medicine, and David K Blood, MD, Assistant Professor of Medicine, Columbia University College of Physicians and Surgeons, New York.

* * *

Radionuclide Angiography, with Paul J Cannon, MD, Professor of Medicine, and Lynne Johnson, MD, Assistant Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons, New York.

* * *

The Thyroid Nodule: A Highly Treatable Condition, with Manfred Blum, MD, Associate Professor of Clinical Medicine and Director of the Nuclear Endocrine Division, New York University School of Medicine, New York.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic video-cassettes and half-inch Betamax formats.

1979 Neighboring

Minnesota Affiliate, at the Normandy Inn in Duluth, Minn. Program. *Heart Health and Exercise,* dealing with physical fitness in general with a special focus on exercise for cardiac patients. Top physical fitness expert Dr Michael J Pollock, director of Mt Sinai Medical Center Cardiac Rehabilitation and Center for Evaluation of Human Performance, University of Wisconsin, Milwaukee, will speak at the meeting. AMA Category I: 6 credits toward PRA. Six prescribed hours credit by AAFP. Interested health professionals and lay persons can contact the American Heart Association, Minnesota Affiliate, 4701 West 77th St, Minneapolis, Minn 55435.

May 14-18: American Psychiatric Association. Conrad Hilton, Chicago, Ill. Info: M Sabshin, MD, 1700 18th St, NW, Washington, DC 20009.

May 16-18: *Cardiac Auscultation and Cardiac Examination,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar ACP, 4200 Pine St. Philadelphia, Pa 19104.

May 17-18: Annual Meeting, Minnesota Medical Association, at the Radisson Hotel, St Paul, Minn. g2-4/79

June 13-16: National Symposium on Racquet Sports. Champaign, Ill. Contact: Jack L Groppel, Conferences and Institutes, University of Illinois, 116 Illini Hall, Champaign, Ill 61820.

Sep 16-20: American College of Radiology, Chicago.

1979 Others

May 24-26: Annual Meeting and Pan Pacific Conference of the American College of Sports Medicine, Sheraton-Waikiki Hotel, Honolulu, Hawaii. Twenty-one hours of Category 1 credits for AMA-PRA. Twenty-one elective credits for AAFP applied for. Registration materials may be obtained by writing to the American College of Sports Medicine, 1440 Monroe St, Dept N-9, Madison, Wis, 53706; or calling 608/262-3632.

June 14-16: *A Postgraduate Course in Gynecology,* second annual co-sponsored meeting of the American Academy of Family Physicians and American College of Obstetricians and Gynecologists, at the Doubletree Inn in Monterey, Calif. Acceptable for 14 Prescribed hours by the AAFP. For registration and hotel reservations, contact Chet Watts, AAFP Dept of Registration and Housing, 1740 West 92nd St, Kansas City, Mo 64114 or call him at 1-800-821-2512.

AMA-ERF

What is it?
What does it do?
How can I participate?

AMA-ERF stands for American Medical Association Education Research Foundation. It is engaged principally in supporting medical education; providing financial assistance to medical students, interns, and residents; fostering scientific and medical research; and providing funds for rural and community-oriented, pilot health projects.

There are two programs within the AMA-ERF program. The Student Loan Fund was established in 1962. Students may borrow up to $2,500 per year, but not more than $12,500 in a seven-year period. Ten banks throughout the United States participate in this loan program. Participating banks will lend $12.50 for each $1.00 held in the guaranteed fund. Where can $1.00 buy more?

The unrestricted funds are those monies contributed by physicians for the school of their choice to be used as their needs require and for those projects not included in the medical schools' budgets. These funds may help a medical school increase its library holdings, purchase laboratory equipment, or to assist in obtaining visiting professorships to enrich ongoing programs.

The work of the AMA-ERF is made possible through physicians' generosity. Last year the State Medical Society of Wisconsin Auxiliary earned $19,614.89 for AMA-ERF. Physicians in Wisconsin contributed $9,155 for a total of $28,769.89.

Of all the many worthy causes to which physicians can contribute, few can match AMA-ERF in providing such lasting and important benefits. Physicians' contributions can be specifically designated to the medical school of their choice or to the loan fund. When making the 100% tax-deductible donation, physicians should indicate where they wish their contribution channeled. Physicians may complete the form below and mail it with their check (payable to AMA-ERF "Auxiliary Fund"). The Auxiliary urges all Wisconsin physicians to take the time to participate.

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News You Can Use

State DHSS finalizes Super-Rule. The State Department of Health and Social Services in mid-March submitted the final draft of the Super-Rule to the Revisor of Statutes for publication in May with an effective date of July 1. Upcoming budget hearings in which the Rule will be considered may change that timetable, however. The SMS Physicians Alliance will be presenting a seminar May 11 at the Society's Annual Meeting in which the Super-Rule and the budget bill will be discussed. Further details on the Super-Rule status appear in this issue.

Second annual awards program for medical speakers underway. The AMA has announced it is now coordinating the second national competition for physician-speakers who represent their state or county medical society in various audience categories. The program is designed to improve the overall effectiveness of medical spokespersons and to stimulate more consciousness for better communications skills in speakers bureaus, meetings, and testimony. The State Medical Society of Wisconsin urges physicians to avail themselves of this fine opportunity. Physicians should submit, with no entry fee, one standard-size audio or video cassette tape for any or all of the seven categories of AMA Speakers and Leadership Programs, Public Affairs Division, postmarked no later than Nov 15, 1979. Categories for the competition include: Television News Show, Television Talk Show, Radio News or Talk Show, The Physician as TV or Radio Host, Public (lay) Audience Speech and Testimony. For more information about the competition and how to enter, contact Diane Upton at the SMS Communications Dept in Madison.

Physician fees increasing at slower rate, report shows. The rate of increase of physicians' fees has been declining since 1975, according to the 7th edition of *Profile of Medical Practice: 1978.* Prepared by the AMA Center for Health Services Research and Development, *Profile* includes the following statistics:

- During 1977 physicians' fees rose 9.2%, compared with 9.7% in 1976, according to the Consumer Price Index. The all-items and all-services indexes rose faster in 1977 than in 1976, although the rate of increase was lower than that of fees in those years. However, more recent CPI statistics (not included in *Profile*) show that the rate of increase of physicians' fees during 1978 was slower, at 8.1%, than the rate of increase of the all-items index, at 9%.
- Between 1969 and 1976 the average physician's net income shows a compound rate of growth of 6.0% per year, while the typical physician's expense grew at a compound rate of 10.4% per year. The average physician's 1976 net income (before taxes) was $59,544, compared with $39,727 in 1969. His expenses were $42,443 in 1976, compared with $21,224 in 1969.
- The average physician had 128.5 patient visits per week in 1976, compared with 126.5 in 1975 and 125.8 in 1974. He practiced medicine 52.2 hours per week in 1976, compared with 51.8 hours in 1975 and 49.9 hours in 1974.

Special Hawaiian tour package available to physicians. The 1979 AMA Interim Meeting of the House of Delegates will be held Dec 2-5, 1979, in Honolulu, Hawaii. Travel Consultants International is coordinating the travel arrangements to Hawaii for the meeting, and have a special tour rate for those physicians attending. However, SMS and AMA physicians not attending the House of Delegates meeting can also take advantage of this special rate — which is considerably below other tour rates. To find out more about this special tour contact Travel Consultants International (TCI), 1025 Connecticut Ave, NW, Washington, DC 20036; or phone (202) 223-8414. ■

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WISCONSIN MEDICAL JOURNAL

MAY 1979

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

Football Injuries

In early April a 19-year-old University of Wisconsin football player died as a result of a massive subdural hematoma. This occurred when he made what was described as "a good, clean tackle," and he lapsed into unconsciousness immediately. Despite this tragic accident no one has suggested that football be banned, and the young man's family absolved the University and the Athletic Department. In a very generous gesture they also donated his kidneys to the kidney bank at the University Hospitals.

Quite by coincidence the April 6th JAMA presented two articles about football injuries. The first[1] reported the national football head and neck injury registry for 1978. This documented 1,129 injuries since 1971 that involved more than 72 hours of hospitalization, surgical intervention, fracture-dislocation, permanent paralysis or death. 550 injuries were fracture-dislocations of the cervical spine, of which 176 were associated with permanent quadriplegia. The study indicates that during the last two decades there has been a decrease in the incidence of direct fatalities, head injuries associated with intracranial hemorrhage, and injuries associated with death. Conversely, cervical spine injuries with fracture-dislocation and permanent quadriplegia have increased. This is believed to be the result of the development of a protective helmet-face mask system that effectively protected the head, but by so doing has allowed it to be used as a battering ram in blocking and tackling techniques, thus resulting in more cervical spine injuries.

Of more interest to Wisconsinites, the second article[2] reports ten football players seen from 1972 through 1977 at the University of Wisconsin Hospitals with clinical and electrodiagnostic evidence of injury to the upper trunk of the brachial plexus. Each had upper limb paresis following one or more blows to the head or shoulders. The development of persistent weakness was often preceded by burning paresthesias in the upper limb. The syndrome of burning paresthesias and subsequent arm weakness frequently is secondary to stretching of the brachial plexus. Typically, the symptoms followed a blow to the head or neck. The article further reported that approximately 50% of the 65 players on the traveling football squad at the University of Wisconsin experienced one or more episodes of burning paresthesias during a regular season. In a five-year period approximately 150 athletes each had at least one episode. The authors recommended that athletes who complain of repeated episodes of burning paresthesias appear to be at particular risk and probably should be withheld temporarily from active participation in contact sports.

Perhaps it is time to re-evaluate the protective devices used in football and to change the playing techniques that use the top of or crown of the helmet as the primary point of contact in a high impact situation.—VSF

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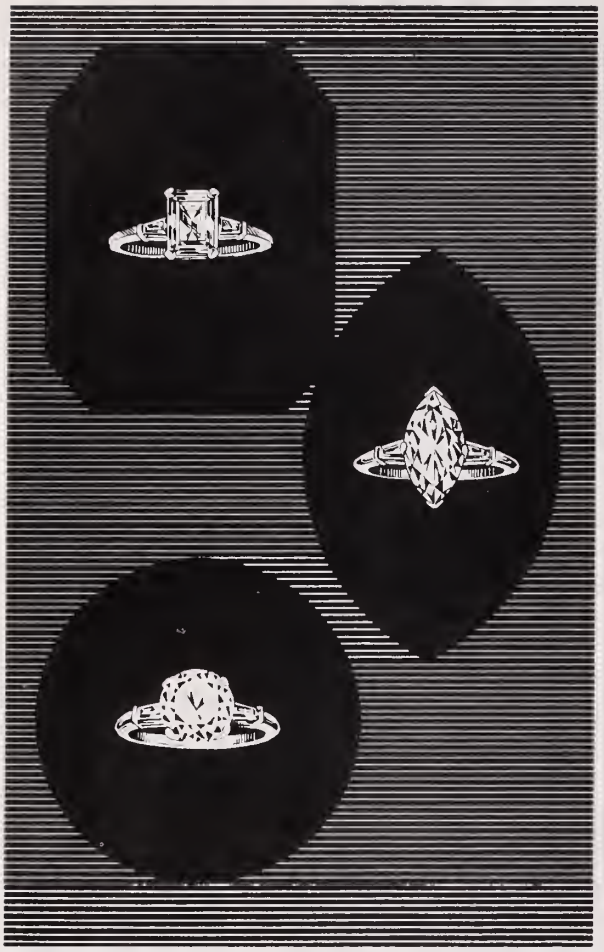
How to win friends, etc

Physicians are acutely aware of the abuse and over-utilization of hospital emergency rooms. Perhaps this has resulted in the attitude of some emergency room physicians and the charges for emergency room services.

The following is an example and, unfortunately, not an isolated incident. When her daughter was awakened late at night with a severe earache, a recently widowed young mother, who was new in the city, turned to an emergency room for help. This was in a large hospital in one of the largest cities in Wisconsin. After the mother waited five hours with her very uncomfortable child, a surly young physician finally deigned to examine the

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.



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offending ear. For this service and a teaspoon of eardrops the charge was $85.

This situation hardly falls in the category of cost containment and certainly does nothing to burnish the image of medicine.—VSF

Ahoy, matey!

A RECENT ISSUE of the *AMA News* quoted a Federal official as saying that, "The Department of Energy does not intend to subsidize physicians for running off to their yachts on weekends and using precious gasoline." This was in answer to a question from an AMA attorney as to whether exceptions would be made for physicians from the proposed two gallon a day limit in the emergency gasoline rationing plan. This pronouncement will certainly leave the thousands of midwest physician-yachtsmen quite bereft.

This is a prime example of bureaucrats in the countless Washington agencies and commissions making more regulations than Congress ever does or more than the administration approves. This is government by the non-elected and it raises the question of where in the government is there regulation of regulations? Last year there were 61,000 pages of government regulations issued compared to 20,000 in 1970, an increase of 305%.

And so, once the 1979 ice age has left Wisconsin I shall silently paddle away in my fourteen foot canoe. My thoughts will turn to Washington and to the great white father in the Department of Energy and the myriad other governmental gobbledygook agencies that so thoughtfully look after all of us little brothers.—VSF

Happy Birthday!

A NEWS RELEASE from Washington reported that there had been an expenditure of $108,000 for a birthday celebration for the Department of Health, Education, and Welfare.

It is gratifying that HEW is gung-ho for cost-containment, or the tab might have been for a really lavish fling. And to salt the wound, the news came out on April 16—income tax day!

—VSF ■

Letters

Preparation and filing of vital records

THE STATE STATUTES concerning preparation and filing of vital records were amended in the last session of the Wisconsin Legislature and the State Medical Society's assistance is needed to alert doctors to the new requirements.

Chapter 69.06(2) now requires all vital records to be prepared in black ink. The reason for this requirement is that microfilm of archival quality must be made on all births, deaths, marriages, and divorces. Colored inks do not produce film of the quality required by state statute.

> "(2) Carefully examine the reports and certificates received from the local registrars and registers of deeds and if any such are incomplete or are completed in other than unfading black ink or are unsatisfactory the registrar shall require such further information or compliance as may be necessary to make the record complete and satisfactory."

Another matter which is of great concern to us is the late preparation of birth and death records by some doctors. This could be the result of clerical persons not completing certificates for doctors signatures within the time established by statutes. Doctors should, however, be aware of ss69.30(1) concerning preparation and filing of birth records and insist that records be provided to them for completion on a timely basis.

> "69.30 Birth certificates by physicians, midwives, and others; Milwaukee county; children born abroad. (1) The physician or midwife in attendance upon any birth shall file a certificate of birth, properly and completely filled out, giving all the particulars required by this subchapter, with the register of deeds of the county in which the birth occurred within 5 days after birth, except that in cities such certificate shall be filed with the health officer . . . All charges for professional services rendered by the physician or midwife in attendance upon a birth shall be unlawful if the birth certificate properly filled out is not reported as herein provided."

The next matter which should be brought to the attention of doctors and the source of most complaints is the prompt completion of death certificates. Some doctors are very lax in signing and dating death certificates resulting in human bodies being disposed of before a death certificate is completed and often before a burial permit is issued. When this occurs, ss69.44 and 69.45 as amended, are not being complied with. This results in our inability to provide survivors with certified copies of records for the purpose of settling estates and obtaining various survivor benefits. We have advised local registrars and funeral directors to notify the county coroner whenever a doctor is unable or refuses to complete a death certificate prior to burial. The State statute reads:

> "69.42 *Burial and removal permits.* (1) The register of deeds, city health officer and the clerk of any incorporated village are authorized to issue a burial or removal permit.
>
> "(2) If any certificate of death is incomplete or unsatisfactory, it shall be the duty of the officer authorized to issue burial or removal permits to call attention to the defects in the certificate and withhold the issuance of the burial or removal permit until a complete and satisfactory record is furnished.
>
> "69.44 *Dispositions of dead; permit requisite.* (1) The body of any person whose death occurs in this state shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of, until a permit for burial or removal is issued, and no burial or removal permit shall be issued until a complete and satisfactory certificate of the death has been filed as herein provided.
>
> "69.45 *Duties as to death certificate and burial permits.* (1) The funeral director, or person acting under authority of s.69.34(2), 155.02 or 156.16, shall be responsible for obtaining and filing the certificate of death with the registrar and securing a burial or removal permit prior to any disposition of the body, except that any person who personally prepares for burial and conducts the funeral of any deceased member of the person's immediate family may obtain and file such certificate."

During the first three months of 1978, there were 3,368 birth certificates out of 23,679 filed beyond the 5-day deadline imposed by statute. Certificates of some babies born in January were not received by the Bureau of Health Statistics until March and April.

As for death certificates, 2,957 certificates out of the 12,607 filed during the first three months of 1978 were signed by Doctors, Coroners, and Medical Examiners more than 72 hours after death was pronounced. It is normal to inter or cremate within 72 hours after death. Occasions do arise where bodies are not disposed of within

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72 hours but the Bureau of Health Statistics has no way of readily determining how many fall in this category except by examination of burial permits.

Many doctors are not completing the interval between onset and death on the death certificate as required by ss69.38 and are not completing item 26 (Autopsy: Yes or No) and item 27 (was case referred to medical examiner or coroner: Yes or No). These omissions result in incomplete certificates and are not acceptable for filing until the desired information is provided the Bureau.

> "69.38(1) The certificate of death shall be made and signed by the physician last in attendance on the deceased and shall specify the time in attendance, the time the physician last saw the deceased alive, and the hour and the day at which death occurred.
>
> "(2) The physician shall state the causes of death so as to show the course of disease or sequence of causes resulting in death, and duration of each."

If I can be of further assistance to your members, please let me know.

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"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

Opinion/Dialogue

Ralph Andreano, economist and former health administrator, discusses the panoply of regulation now facing healthcare providers

Economics and Medicine

For the past few months my attention has been directed toward a number of issues that concern the medical profession and other health professionals. One issue deals with the panoply of regulation that now faces any healthcare provider. I have some thoughts on the impact of this and how and why it could or might be changed in the years ahead. Another issue concerns what I call the economics of clinical practice; that is, the economics of the way physicians practice medicine. Having recently presented my views to physicians of the Fond du Lac County Medical Society and having been rather rudely treated (albeit enjoyable nonetheless), I felt compelled to address my thoughts to other physicians in the State. And the Editorial Board of the *Wisconsin Medical Journal* has allowed me this opportunity.

Health regulation

As physicians well know, the health sector in the past five years has been wrapped in a blanket of regulation, most of it emanating at the Federal level from PL 93-641—the health planning law. The law is translated at the State level through areawide health systems agencies (HSAs), Certificate-of-Need regulations, hospital rate-setting bodies, and other such boards and commissions.

In general there are a few points that should be made about this regulatory framework:

1. The law is mostly directed to what economists call the SUPPLY SIDE; *ie*, to restrict the amount of *new* resources (beds, equipment, manpower, etc) going into the industry.

2. Nothing in the regulatory framework is addressed, again to what economists call, the DEMAND SIDE.

3. Very little emphasis is put in this regulatory/planning framework that deals with, again what economists would call, TOTAL OUTPUT; *ie*, improvements in health whether measured by conventional health status indicators or by some elusively defined perception that "health" is improved as a consequence of society's investment in medical capital, manpower, and technology.

It is an interesting note on our times that while the national climate toward government regulation is considerably softening—witness the massive deregulation of the airline industry now underway—in health the situation is just the opposite: regulation is on the increase and many informed persons are clamoring for more of it rather than less. What is it about the health sector that has produced this state of affairs? There are three principal reasons for this:

1. **Market failure.** In normally functioning markets the price system allocates resources for production, investment, and consumption. As we all know, healthcare is not like any other market. The result in the past 25 years has been to illustrate vividly that society cannot rely on private market forces to allocate resources devoted to the production and consumption of healthcare services in an efficient and equitable way.

Editor's note: In approving for publication Professor Andreano's article on "Economics and Medicine" the Editorial Board recognizes the controversial nature of his comments. However, the Board also believes in open dialogue to vent such issues, perhaps resulting in a better understanding and perspection between physicians and those who by law or otherwise are involved in the planning and delivery of health services. The views of Professor Andreano should not be construed as those of the State Medical Society. The WMJ welcomes comment from its readers.

2. **Growth of public programs.** Because private markets have failed, resulting in large segments of the population not being adequately cared for—notably the aged, infirm, and poor—public programs such as Medicare and Medicaid were funded to correct the failures of the private marketplace. The growth of public programs has had two major effects on the regulatory climate: (a) they contributed greatly to inflationary pressures which made government very concerned about rising costs and expenditures; *ie,* demand was greatly increased without correspondingly fast enough increases in the supply of resources, thus prices rose; and (b) because public programs purchased care from the private medical provider, markets for the aged and poor, methods and levels of reimbursement, assurances of adequate "quality" and the like put government and providers face to face over how and by how much regulation would ensue in order to "safeguard" the huge amount of public monies being spent. And there was a final and hidden consequence of the great growth in public programs: by providing healthcare for the aged and poor and contributing to inflation of medical care prices, public programs raised the cost of medical care to all of us. This combination of effects led to the third principal reason that government regulation is now so active a fact of life for the health industry.

3. **The phenomenal rise in total personal health expenditures.** We spend 9% of the Gross National Product (GNP) on personal health; total expenditures for inpatient hospital care, long-term care, drugs and laboratory tests, etc have risen phenomenally in the last decade. Many politicians and policy makers look at this growth in total expenditures and say, "What are we doing about this?" The answer is: We must regulate this industry which is now "out of control" before we sink 15 to 20% of the GNP into it.

Perhaps there are other explanations for the current penchant for government regulation, but these three seem to be enough. But what is it that one wants to accomplish through regulation? Do the costs of regulation exceed the benefits? Indeed, what *are* the benefits of regulation and who receives them?

Now that I am a Professor again and not a "hated, ill-informed, health czar," I can in all candor state that for an economist of my ilk and persuasion government regulation is disliked just as much as physicians dislike it, although perhaps for different reasons. The economist sees regulation as necessary when private markets fail—and that certainly is the case in health. But the economist fears regulation because it is always a *less efficient* solution to economic problems than private market forces. Moreover, the industry being regulated always winds up controlling the regulatory process and apparatus and uses the regulation to its own advantage. Regulation confers privileges and benefits to some but excludes others. A Certificate-of-Need (CON) is tantamount to granting someone a franchise; in some cases almost conferring highly protected monopoly status. New innovations, new entrants, and new ideas find it difficult to thrive in an industry dominated by regulation. For government regulation to succeed in doing what private market systems have failed to do is extremely difficult; at best the regulation may reduce some of the grossest distortions that private market failure has created, but it cannot supplant smooth, efficient, competitive market forces where the price system allocates resources. It is an *imperfect substitute* for competitive market forces.

Yet when we turn to the health industry, what are the choices? It is no longer a choice between private markets and/or government regulation. Private markets have not functioned well and have produced all kinds of welfare distortions. The choice now is not regulation or no regulation but *what kind of regulation.* The model we are presently using (those things under PL 93-641: HSAs, SHPDAs, CON, PSRO,* prospective rate setting for hospitals, maybe even nursing homes) has serious limitations *qua* regulation:

First, we ask: What are the objectives of this regulatory model?

- Is it to "control cost?"
- Is it to "improve access?"
- Is it to "maintain and improve quality?"

If these are the objectives, on the face of it, they conflict with each other. Also, we must ask: How can the regulatory theory we operate under now achieve *any* objective if it only impacts on one side of the market; *ie,* the SUPPLY SIDE and does not address the DEMAND SIDE? What these questions seem to suggest, therefore, is that the full array of regulatory tools now in use is incomplete; and left alone, we are not likely to achieve perhaps the most central objective: namely cost containment (by which I mean a leveling or slowdown of total expenditures for personal healthcare).

To impact directly on the DEMAND SIDE, some expansion of private market forces (such as

*HSAs=Health Systems Agencies; SHPDAs=State Health Planning and Development Agencies; CON=Certificate-of-Need; PSRO=Professional Standards Review Organization.

co-insurance, deductibles, etc) *plus* some additional regulatory tools will be required. From the point of view of physicians, the likely form that "demand regulation" might take is twofold: (1) bargaining with physicians by the "leverage" effect of participation in publicly financed programs over their "total income," or (2) bargaining with physicians over their "fees" and the economic basis used to establish fees. Personally, I think the future will see abandonment of the "usual, customary, and reasonable" fee concept. For my taste, and also because I think the economic results would be more beneficial to society *and* physicians, I would rather see bargaining over "total income" rather than over "fees" charged for a unit of service. Whether physicians like this, it is a fact that physicians have control, to a very great extent, of how much of their services and the related ancillary services a patient—and thus society—will consume. You order the tests, you place patients in hospitals, and you require follow-up visits and the like. Recent empirical studies have shown that for every $1 spent on physician services, an additional $3 is generated elsewhere in the medical services system.

My regulatory notion here would be simple: we guarantee physicians a certain level of income based on a formula which rewards you with higher income the more "other expenditures" are reduced. I have expounded on this idea elsewhere (*Wisconsin Medical Journal,* July 1978) and will refer you to that.

Economics of Clinical Practice

This notion, however, that the way to address cost containment of total health expenditures through the physician, brings me to the second issue: what I call the economics of clinical practice. This is a delicate subject and, therefore, requires a cautious approach. First, let me underscore two things: (1) I believe physicians do not willfully provide treatments and tests unless they think they will help their patients; that is, I believe physicians are basically honest and ethical; (2) physicians do not care if the cost of some procedure is "excessive" if it will save a life; they place no economic limit on the value of life. I want to emphasize that I do believe these two caveats are true. Nonetheless, the consequences of these two caveats have profound significance when one is concerned with how much of society's resources are spent in caring for patients. I should also note that the reality and necessity (for malpractice reasons) of defensive medicine also are complicating factors in understanding the points I shall make about the economic consequences of how physicians practice medicine. What I want to comment on may be thought of as follows: What is the effectiveness and the efficiency of certain preventive, curative, and diagnostic procedures and treatments?

Effectiveness. Medical practice in America tends to assume as correct too many hypotheses concerning treatment and the application of new medical technology. It incorporates these into routine clinical practice in the *absence* of solid scientific tests of the worth of such hypotheses. Many preventive treatments and technologies are applied, clinically, before adequate testing, especially testing by randomized control. A classic example is prevention of carcinoma of the cervix through the taking of smears. Most evidence suggests that the death rate from carcinoma of the cervix was falling *before* smears were introduced. As A L Cochrane wrote:

> "No convincing evidence has been published of a greater fall of this death-rate in areas where there has been a high coverage of the female population when compared with similar areas where little work has been done." (A L Cochrane, *Effectiveness and Efficiency: Random Reflections on Health Services,* Nuffield Provincial Hospitals Trust, 1972, p 27).

There are other examples as well: the acute ischemic heart disease studies in England in which hospital treatment (including time in a coronary care unit) is compared with home treatment. The American studies comparing drug therapies against diet in the treatment of diabetes. The recent furor raised over fetal monitoring, and the somewhat longer-standing dispute on whole-body CT scanners are two other examples.

The point here is that prior to scientific verification of the effectiveness of certain preventative and curative therapies, their widespread use in clinical practice generated a lot of other expenditures in the health system.

"Government regulation of the health industry is on the increase . . . What is it about the health sector that has produced this state of affairs? There are three principal reasons for this: (1) market failure, (2) growth of public programs, and (3) the phenomenal rise in total personal health expenditures."

The Make

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent reference product. know, there is sub literature on this s affecting many dr cluding such antib as tetracycline an thromycin. The re drug recalls and c actions affirms str that there are diffe among pharmace companies and th products. Researc intensive compani have far better rec than those that do search and may p minimum quality ance.

MYTH: Industry fa only "expensive" br names and denigra generics.

FACT: PMA comp make 90 to 95 per the drug supply, i ing, therefore, mo generics. Drug no clature is not the i tant point; it's the tence of the manu turer and the inte the product that c

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
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Tenuate® ⓒ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976
MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.
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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Oillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

Whether overweight is a complicating factor... or just uncomplicated overweight.

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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particularly in the elderly, diabetics, and those with suspected or confirmed renal insufficiency (see Warnings). If hyperkalemia develops, substitute a thiazide alone.

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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CIII

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Scientific Medicine

Refer to: Wagner M, Kiselow MC, Goodman JJ, et al: The relationship of the intrauterine device, actinomycosis infection, and bowel abscesses. *Wisconsin Med J* 78:23-26 (May) 1979

Key words: Intrauterine device, actinomycosis infection, bowel abscesses

The relationship of the intrauterine device, actinomycosis infection, and bowel abscesses

Marvin Wagner, MD; Mark C Kiselow, MD; J Jay Goodman, MD; Paul Biever, MD; and **Lawrence Gill, MD,** Milwaukee, Wisconsin

• **The injurious effect of an intrauterine device as a contributing factor to the development of an actinomycotic infection in the female genitalia and associated abdominal viscera is reported. The treatment consists of combined specific antibiotic and surgical treatment. The literature also is reviewed.**

ACTINOMYCOSIS INFECTION involving the female genital tract has been an increasing morbid entity since the advent of the intrauterine device. Actinomycosis is a chronic granulomatous suppurative disease caused by *Actinomyces israelii.* The organism is an anaerobic, Gram-positive fungus and a "normal" inhabitant of the gastrointestinal tract, oral pharynx (*ie,* tonsil, infected teeth), but NOT of the healthy vaginal canal, intrauterine cavity, or cervix.

Doctor Wagner is Clinical Professor, Dept of Surgery and Anatomy; Doctor Kiselow is Assistant Clinical Professor, Dept of Surgery; and Doctor Goodman is Instructor, Dept of Surgery, Medical College of Wisconsin, Milwaukee. Doctor Biever is Attending Staff, Dept of Gynecology, and Doctor Gill is Resident Physician, St Michael Hospital, Milwaukee. Publication support provided. Reprint requests to: Drs Wagner, Kiselow & Goodman, Ltd, 2300 North Mayfair Road, Milwaukee, Wis 53226. Copyright 1979 by the State Medical Society of Wisconsin.

In the case being reported the presence of an IUD (Dalkon Shield) was the significant cause of the actinomycotic infection. This case also will illustrate the propensity of "metastatic" abscesses that are common with actinomycotic infections.

Case report. A 38-year-old white woman presented with a two-month history of pelvic cramps, menorrhagia, and "weakness." She also complained of occasional night sweats, a six-pound weight loss, vaginal discharge, and a low-grade fever for six weeks prior to admission.

The patient had no significant medical history except for a calcified pelvic mass (fibroid uterus) that had been noted by her gynecologist one year before. She had had an intrauterine device (Dalkon Shield) in place for several years.

The patient was admitted on the gynecology service at the hospital for romoval of the IUD, dilatation and curettage, and probable hysterectomy. On admission the patient appeared pale with a blood pressure of 120/70 mm Hg, a pulse of 100, and a temperature of 100 F. The uterus was approximately the size of a four-month pregnancy associated with a pelvic mass involving the rectosigmoid.

Admission laboratory studies showed a hematocrit reading of 22 vol%; hemoglobin level, 7.2 gm/100 ml; white blood cell count, 19,000/cu mm with a differential count of 85 segmented neutrophils, 12

lymphocytes, 1 monocyte, and 2 basophils. The alkaline phosphatase was slightly increased, and the albumin was slightly decreased. Other laboratory studies were within normal limits.

Since the patient had a vaginal discharge, fever, and a pelvic mass associated with a tender and enlarged uterus, she was prepared for removal of her IUD and dilatation and curettage. She had several blood transfusions and intravenous penicillin for 48 hours prior to surgery, since her initial cultures taken of the vagina and cervix showed *Actinomycosis israelii* sensitive to penicillin.

Her IUD was removed and a dilatation and curettage was performed. Cultures were taken of the intrauterine device (Fig 1) and the curettings. The mass involving the rectosigmoid as well as the enlarged fibroid uterus were confirmed on pelvic examination. The histologic diagnosis of moderate squamous metaplasia was made on microscopic examination. Fungal colonies in the detritus were noted on the IUD and curettings (Fig 2). The patient's tempera-

FIGURE 1—Intrauterine device with attached endometrial fragments and bloody detritus.

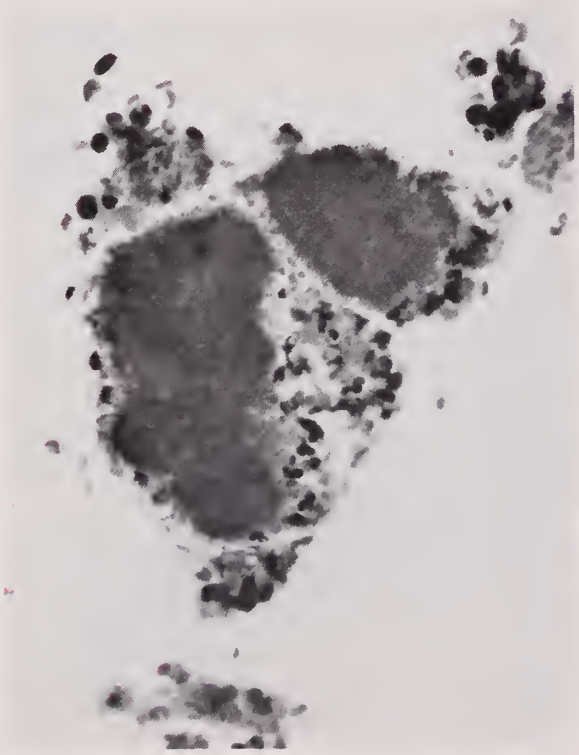

FIGURE 2—Fungal colonies in detritus removed from intrauterine device.

FIGURE 3—Area of narrowing and irritability in the distal sigmoid colon which radiographically appeared to be inflammatory.

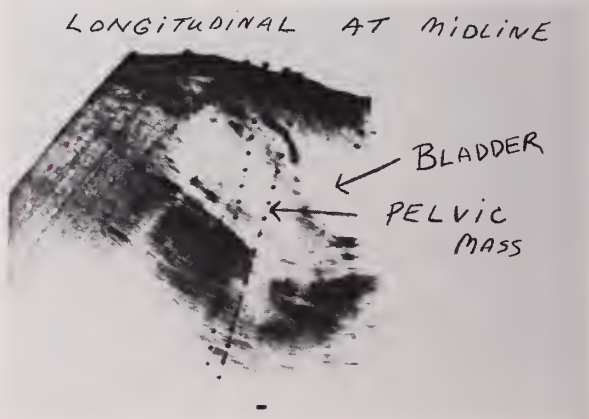

FIGURE 4—Abdominal echogram: midline pelvic mass, as labeled.

ture was 102 F after the surgery. Her antibiotic therapy, consisting of intravenous clindamycin and penicillin, was continued until her temperature "plateaued" at 99.4 F.

The pelvic mass associated with the fibroid uterus was then evaluated. No intrinsic lesion was found by proctosigmoidoscopy or colonoscopy, except for some "narrowing" of the rectosigmoid. An oral

FIGURE 5—Fungal granuloma involving transverse colon and mesentery.

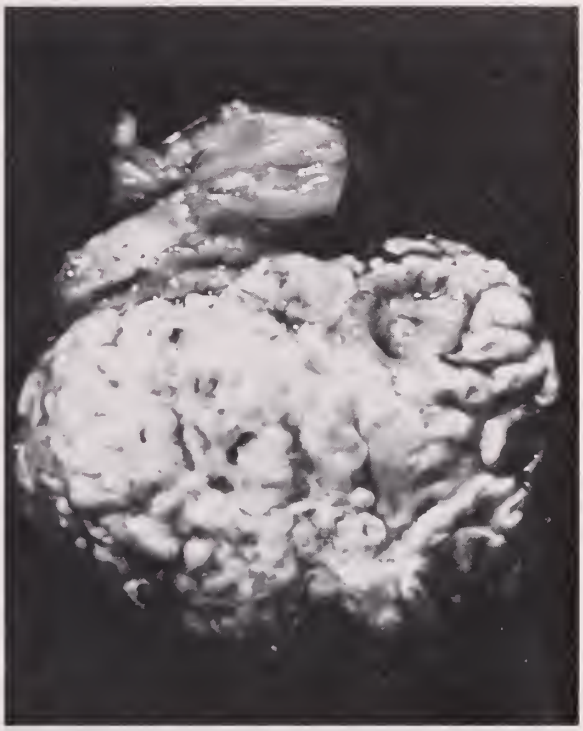

FIGURE 7—Extensive fungal granuloma of entire ovary. Note cerebriform pattern.

FIGURE 6—Fungal granuloma of colon (above) extending into colonic mucosa.

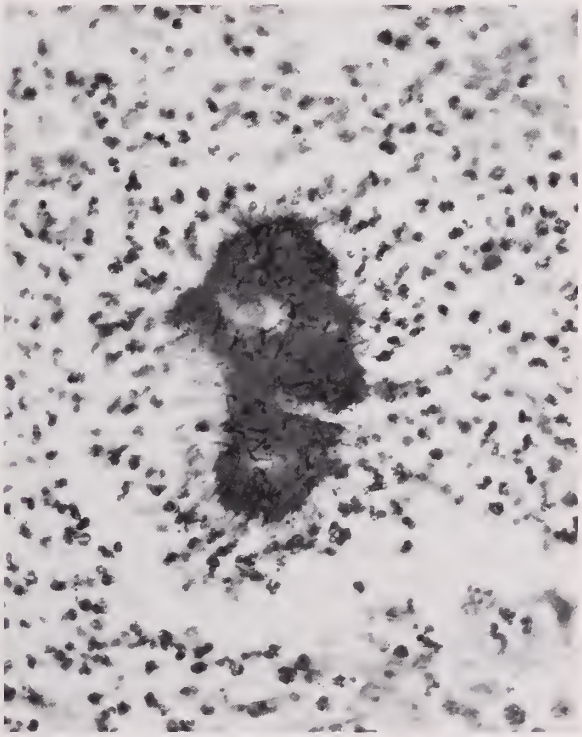

FIGURE 8—Photomicrograph of Actinomyces israelii *colony identified in ovarian granuloma.*

cholecystogram was normal. A barium enema demonstrated an area of narrowing and irritability in the distal colon (Fig 3). No intrinsic mass was identified. An abdominal ultrasound (Fig 4) showed a midline, 7 or 8 cm pelvic mass that was separate from the uterus. Within the uterus was a 3-cm calcific area that had been observed a year before.

The patient was prepared with a mechanical bowel preparation and erythromycin (base). Upon entering the abdominal cavity there were numerous adhesions and several granulomatous abscesses involving the right ovary and both Fallopian tubes. A pericolic transverse colon abscess involving the omentum also was found. The pelvic mass that was palpable on examination and associated with the fibroid uterus was found to be an abscess in juxtaposition to the sigmoid colon.

The operative procedure consisted of lysis of multiple adhesions, a subtotal hysterectomy and bilateral salpingo-oophorectomy, omentectomy with a transverse colon resection leaving a proximal colostomy and a distal mucous fistula. Microscopic examination of the abscesses was diagnostic for actinomycosis. Intravenous penicillin and clindamycin were utilized for treatment of the actinomycosis and bacteroides that were cultured from the abscesses.

The patient had an uncomplicated postoperative course, and she was discharged 12 days after surgery with a functioning colostomy. The intrauterine device (Fig 1), colonic abscess, Fallopian tubes, uterus, transverse colon (Figs 5 and 6) and ovaries (Figs 7 and 8) had microscopic evidence of actinomycotic infection.

The patient was readmitted two months later to reestablish continuity of the colon. She had been maintained on tetracycline since her first surgery. On admission her physical examination and laboratory profile were within normal limits. Operative findings showed that the abdominal cavity was free of any visable inflammatory or infectious process. The patient had an uncomplicated postoperative course after reestablishing the continuity of her colon, and she was dismissed on her seventh postoperative day with a normally functioning bowel.

Discussion. Actinomycotic infections usually occur in three anatomic sites in the human: cervicofacial, thorax, and abdomen. In 1938 Cope[1] reported on 1330 cases; 63% of the cases were cervicofacial, 15% thoracic and 22% abdominal. Actinomycosis is a suppurative disease caused by *Actinomyces israelii*. It is a normal inhabitant of the mouth and gastrointestinal tract, but not of the vaginal canal.[2] The infection is said to usually require compromise of the integrity of mucosal lining of the gastrointestinal tract and the presence of other anaerobic organisms in order to develop in man.[1] The pathway for infection in the female internal genitalia is by direct extension from the patient's bowel (*ie* perforated bowel abscess with adnexal involvement), or by crossing the perineum and extending proximally through the vagina and cervix with an intrauterine device providing the site by injuring the endometrium.[3] Extension of the abscesses when they occur takes place by local extension and may include any adjacent organ, or via the bloodstream, but rarely via the lymphatics. In review of the world literature it seems that Barth[3] and Tietze's[4] papers are the first papers that indict the intrauterine device as an etiologic factor for actinomycosis of the female genital organs.

Actinomycosis of the female genital tract is rare. Richter, et al,[5] in their review of the world literature in 1972, showed that between the years of 1890 and 1934 there were 101 cases reported; 71 cases between 1935-1949; and 25 cases in the years 1950-1964.

Schiffer[6] added 10 cases with his paper, illustrating the association of actinomycotic infections with intrauterine contraceptive devices.

Summary. A case of actinomycosis of the female genital tract is reviewed. The possibility of ascending infections with metastatic abscesses from an intrauterine device is discussed.

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EDITOR'S NOTE: The following is an abstract of a paper read before the Milwaukee Gynecological Society meeting held in Milwaukee on Nov 5, 1974

The Dalkon Shield controversy—Structural and bacteriological studies of IUD tails.

HOWARD J TATUM, MD, PhD; FREDERICK H SCHMIDT, MA; DAVID PHILLIPS, PhD; MACLYN McCARTY, MD; WILLIAM M O'-LEARY, PhD: *JAMA* 231:711-717 (Feb 17) 1975

The recent report of 209 cases of septic spontaneous abortion and 11 maternal deaths in the United States in women using the Dalkon Shield intrauterine device (IUD) raised the question about a possible causal relationship between IUD and pelvic sepsis. It is essential to determine whether or not this sepsis is unique to the Dalkon Shield or generic to all types of IUDs. Our studies permit the conclusion that the tail of the Dalkon Shield is structurally and functionally different from the tails of the four other IUDs tested. The unique characteristics of the Dalkon tail theoretically could provide a mechanism whereby pathogenic bacteria from the vagina enter the uterine cavity and cause sepsis. ■

Refer to: Gallagher WB: Meckel's diverticulum. *Wisconsin Med J* 78:27-29 (May) 1979

Key words: Meckel's diverticulum

Meckel's diverticulum

William B Gallagher, MD, LaCrosse, Wisconsin

THE FETAL OMPHALO-MESENTERIC duct, between the yolk sac and the hindgut, should disappear around the sixth fetal week; failure to obliterate leaves either an omphalo-mesenteric fistula, an enterocyst, a fibrous band, or an outpouching, usually on the antimesenteric border of the distal ileum.

First described by Fabricius Hildanus,[1] anatomist and teacher of William Harvery at Padua, in 1598, Johannes Meckel,[2] Prussian anatomist, established its anatomy and embryology between 1808 and 1820. What is their incidence? Weinstein[1] cites these studies.

Meckel's diverticulum affects about 2% of the population (or less, cf. Table 1), lies two feet proximal to the ileocecal valve, usually is two inches long, affects males twice as often as females, contains two types of ectopic tissue (gastric and pancreatic) and has three major complications—hemorrhage, inflammation, and intestinal obstruction, from volvulus around the diverticular attachment or from diverticular intussusception (Haller).[3]

Since Meckel, in 1812, said that 25% of them develop complications, a concensus developed that all diverticula found, whether symptomatic or not, should be removed (Söderlund,[2] Haller,[3] Weinstein[1]), although Weinstein[1] says "The majority of Meckel's diverticula remain asymptomatic throughout life. However, (as the) seat of overt disease . . . presenting symptoms . . . mimic many . . . intra-abdominal disease states."

Soltero and Bill,[4] in 1976, reviewed 202 cases of diseased Meckel's diverticula from the 26 hospitals in Seattle, a population area of 1,143,000 people over a 15-year period. Assuming that 2% of these people were born with diverticula, and finding 202 diseased diverticula removed, these authors calculated that 4.2% of people with the abnormality will have diverticular disease during their lifetimes; they concluded that prophylactic removal of asymptomatic diverticula is rarely justified. Their graph (Fig 1) shows the diminishing risks of complications through life starting with a high of only 4.2% at birth.

Study material. Between 1968 and 1978 at the St Francis Hospital, LaCrosse, Wisconsin, a 350-bed general community hospital, we discovered only 25 Meckel's diverticula—17 in males, 8 in females.

Incidental Meckel's diverticulum. Ten diverticula were incidental findings at other surgery—five appendectomies, two biliary tract procedures, one adhesive small bowel obstruction, one right hemicolectomy, one vagotomy and gastroenterostomy.

This was over a 10-year period when 6453 abdominal operations were performed at our hospital, including 1764 biliary tract procedures, 417 gastric operations, 1454 colon or small bowel interventions, 822 hysterectomies, 1488 appendectomies and 482 miscellaneous, plus 26 aortic and iliac arterial surgery. Seven general surgeons and six gynecologists did the work. Each of these operators explored the abdomen by palpation from his own vantage point, in the absence of local septic contraindications. None systematically sought out Meckel's diverticula, except on appendectomies where a normal appendix was encountered.

Our most recent case of incidental removal of a diverticulum was in a 13-year-old boy with appendicitis. His postoperative course was marred

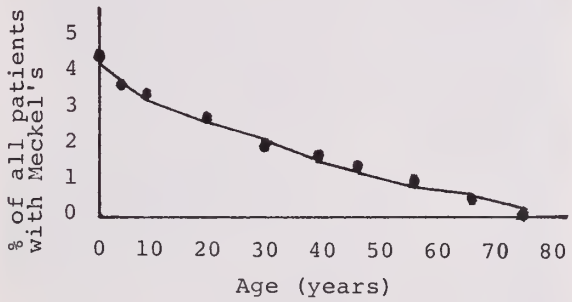

FIGURE 1 (from Soltero and Bill[4])—Percentage of risk by age of future disease developing in patients with Meckel's diverticulum (Reproduced with author's permission)

Table 1 (from Weinstein[1])—Autopsy incidence of Meckel's diverticulum

Author	*Year*	*Series*	*Meckel's*	*Incidence(%)*
Balfour	1911			2.0
Hunt	1924	1000	3	0.3
Christie	1931	5768	63	1.1
Harkins	1933	2400	41	1.7
Kittle	1947	5000	10	0.5
Jay	1950	4200	48	1.2

Publication support provided. Reprint requests to: William B Gallagher, MD, Skemp-Grandview Clinic, SC, 815 South Tenth St, LaCrosse, Wis 54601. Copyright 1979 by the State Medical Society of Wisconsin.

Table 2—Pathology in 12 bleeding Meckel's diverticula		
Age range: 5 months to 22 years; male 11, female 1		
Gastric mucosa		10
Alone	1	
Plus duodenal mucosa	1	
With polyp	1	
With ulcer	7	
Acute diverticulitis		2
TOTAL		12

by small bowel obstruction from ileal stenosis at the Meckel's diverticulum resection site requiring re-operation. Soltero and Bill[4] cite a 9% extra morbidity with prophylactic removal of asymptomatic diverticula, and calculate that 800 normal diverticula would have to be removed to save one life.

Bleeding Meckel's diverticulum. Bleeding results from peptic ulceration of ileal mucosa next to aberrant gastric mucosa in the diverticulum. Table 2 lists the pathology in our 12 patients operated for bleeding.

Small bowel obstruction. A 12-year-old boy was operated for obstruction from an inflamed diverticulum; a 63-year-old man had an obstructing band from a diverticulum.

FIGURE 2—Photo gross fish bone perforating Meckel's.

Perforation. A 56-year-old woman with lower abdominal pain, fever, and leukocytosis had a suppurative perforating Meckel's diverticulitis due to inspissated fish bones (Fig 2). She recalled swallowing bones while eating fish a month earlier.

Diagnosis. Early in this series our radiologist diagnosed Meckel's diverticulum in an 11-year-old boy with melena (Fig 3). Operation confirmed his report: "Arising from the . . . small bowel . . . two feet proximal to the ileo-cecal valve is a . . . Meckel's diverticulum . . . with an ulcer crater . . ."

This was our only such demonstration; we cannot depend on barium from either direction to show Meckel's diverticula. Must the surgeon operate with no certainty of finding a lesion? Or procrastinate dangerously?

Abdominal scanning. After Brown—Grant[5] (1961) showed that iodine concentrates in the stomach as well as in the thyroid, Wolff[6] demonstrated that technetium (^{99m}Tc-pertechnetate), like iodine a member of the periodic table group VII, also concentrates in the parietal cells and gastric juice (1964). Harder, Alexander, and Kennedy[7] (1967) confirmed this and suggested technetium might concentrate in ectopic gastric tissue, *eg* in Meckel's diverticula. Jewett, Duszynski, and Allen[8] (1970) scanned two young patients with intestinal bleeding and found: (1) stomach outline, within 15 minutes, (2) bladder outline, after 30 minutes, and (3) an area of abnormal uptake in the mid-abdomen. Operations showed bleeding Meckel's diverticula.

FIGURE 3—Barium enema showing Meckel's.

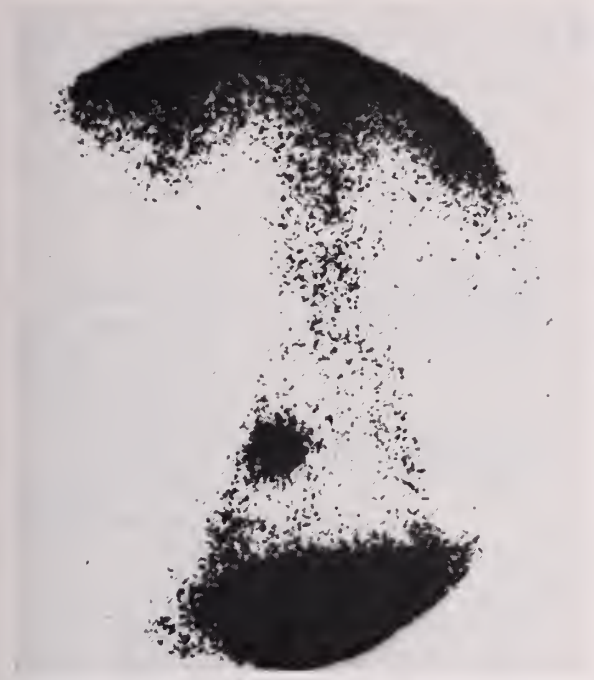

FIGURE 4—^{99m}Tc-Pertechnetate scar showing Meckel's.

Our experience. Figure 4 shows a ^{99m}Tc-pertechnetate abdominal scan on a 16-year-old boy with melena. An ectopic area of uptake shows in the mid-abdomen. At operation we found a Meckel's diverticulum swollen with a bleeding gastric polyp (Fig 5 and Fig 6).

Summary. The main complication of Meckel's diverticulum is bleeding in young males (11 of our 12 patients).

The radionuclide ^{99m}Tc-pertechnetate can demonstrate such gastric-mucosa containing diverticula.

Meckel's diverticulum remains a possible cause of difficult-to-diagnose intra-abdominal conditions, but most never become symptomatic and their routine removal is not indicated.

ACKNOWLEDGMENT: Photographs courtesy of Dr Abbas Rahimi, Pathology Department, and Mr Richard Garden, Audiovisual Department, St Francis Hospital, La-Crosse.

FIGURE 5—Photo gross Meckel's with bleeding gastric polyp.

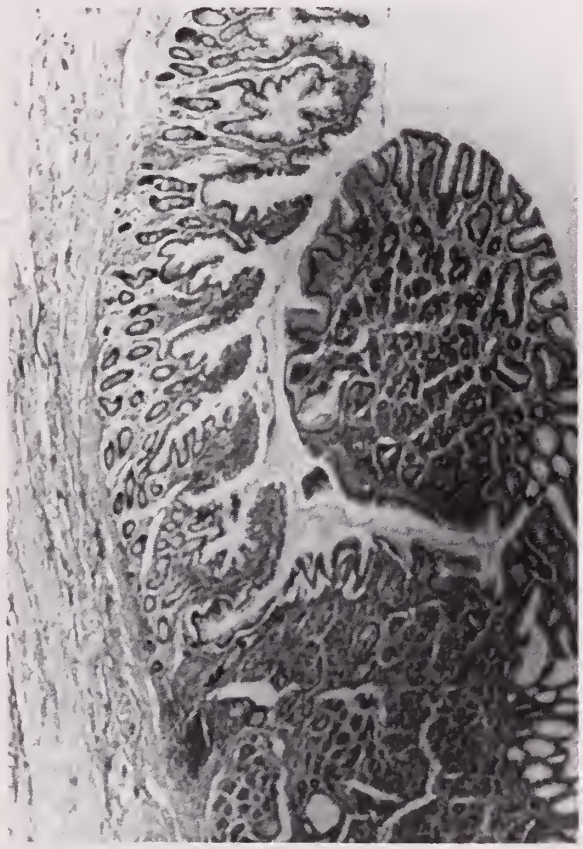

FIGURE 6—Photomicrograph of Figure 5.

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Sunscreens: Skin types and protection factor

Refer to: Cripps DJ: Sunscreens: Skin types and protection factor. *Wisconsin Med J* 78:30-32 (May) 1979
Key words: Sunscreens, sun protection factor, skin sensitivity to sunlight

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• Twenty-three commercially available sunscreens were studied in the laboratory to determine the sun protection factor (SPF) against measured and selected spectrum of ultraviolet radiation. Since individuals who are sensitive to sunlight can be conveniently classified into four types: (I) always burn, never tan, (II) always burn but sometimes tan, (III) sometimes burn, always tan, and (IV) never burn, always tan, it is suggested that the sunscreens be used with the appropriate skin type. Persons with a type I sensitivity might select a sunscreen with a high SPF (13-15) such as Supershade 15, Eclipse, Presun or Pabonal; for those with type II Piz Buin 6, Maxafil, Sundown, or Sea & Ski which have SPFs in the range of 8-11; for type III Piz Buin 4, RVPaque, Uval, and Sungard, which have SPFs in the range of 6-8; for those with type IV, Piz Buin 3, RVP petrolatum and Coppertone might be selected with SPF of 3-5, as the less protective sunscreens would block less ultraviolet light and should permit faster tanning.

COMMERCIALLY-AVAILABLE sunscreens were studied in the laboratory to determine their protection factor (PF) against ultraviolet radiation and with the data obtained to suggest a range of sunscreens that could be used with the appropriate skin type of the population.

The dose of radiation, measured in mWsec/cm^2, required to produce minimal erythema on the skin (MED) before the application of the sunscreen on each individual was compared with the dose required to produce minimal erythema (MED) after the selected sunscreen had been applied. The number of MEDs protected by the sunscreen is known as the protection factor (SPF).

$$\text{SPF} = \frac{\text{MED on Protected Skin}}{\text{MED on Unprotected Skin}}$$

For the purpose of definition, ultraviolet radiation that causes terrestrial sunburn in the range of 290-320 nm is referred to as UVB, and ultraviolet in the range of 320-400 nm which causes minimal sunburn is referred to as UVA.

Topical sunscreens are designed to protect the skin from ultraviolet light. The sunscreens tested are listed in Table 1 and contain chemicals capable of absorbing or reflecting ultraviolet light.

Chemicals (absorbing UV)	*Example*
Para-aminobenzoic acid	Presun, Pabanol
Para-aminobenzoic ester	Supershade 15, Eclipse, Sea & Ski, Sundown, Pabafilm
Cinoxate and/or Menthyl Anthralinate	MAXAfil, Afil, RVPaque
Benzones	Sungard, Uval, Solbar, Panultra, Piz Buin
Chemicals (reflecting UV)	
Titanium dioxide, Talc, Zinc Oxide	RVPaque, Zinc Oxide Paste

If we consider the shortest wavelength of UV reaching the earth's surface to be 290 nm and multiply the data on the action spectra of normal skin (Cripps and Ramsay, 1970)[1] in the range of 290-320 nm by the calculated global radiation, an erythema product curve is formed. McCullough calculated the peak of this erythema to be at 306 nm which would be the most effective for producing sunburn. Sunscreens should be able to protect in this range. In this study sunscreen PFs were tested at 305 nm and with the full spectral range of a xenon lamp.

MATERIALS AND METHODS

Subjects

The mid and lower dorsa of the trunk of 43 Caucasian volunteers were irradiated to determine minimal erythema dose.

Apparatus

A 2.5 KW xenon arc and a prism grating monochromator.[1] Subjects were irradiated with (a) 305 nm (4 nm bandwidth) described elsewhere,[3] (b) a full spectrum of the xenon arc using a recently designed solar simulator filtered to give a spectral range of 300 nm - 700 nm similar to sunlight. The xenon arc is focused onto an Oriel optical integrator to give a uniform homogenous light source with collimating lens and mirror to irradiate the skin with parallel light simulating sunlight. The MED was determined at 24 hours. Sunscreens were applied with a 50 UL pipette SMID to measured areas of skin to give a concentration of 2 UL/cm^2. Test sites were retested 30 minutes later with measured UV administered in the range of 3-18 MEDs depending on the sunscreen. The protection factor was evaluated at 24 hours by determining the dose required to produce minimal erythema.

Presented before the American Academy of Dermatology, Dallas, Texas, December 1977. From the Section of Dermatology, University of Wisconsin Center for Health Sciences, Madison, Wisconsin. Supported by NIH Grant AMO 9995-11. Reprint requests to: Derek J Cripps, MD, Dermatology, 600 Highland, Madison, Wis 53792. Copyright 1979 by the State Medical Society of Wisconsin.

Table 1—Sunscreen protection factor at 305 nm

SUNSCREEN	*Mean SPF*	*Range*	*No.*
PRESUN (5% PABA)	13.5	12-16	15
PIZ BUIN 6 (methoxy-cinnamate, benzophenone, PHB)	11.0	9-13	15
SUNDOWN (3.3% octyl-dimenthyl PABA)	10.0	9-11	10
MAXAFIL (4% cinoxate, 5% menthyl anthralinate)	9.5	8-12	20
SEA & SKI (4% isoamyl-dimethyl PABA)	9.0	7-11	10
RVPaque (red petrolatum, zinc oxide, methoxycinnamate)	8.0	6-9	13
AZTEC (homomenthyl salicylate, dimethyl benzoate)	8.0	6-10	10
PIZ BUIN 4	7.0	6-9	13
SOL BAR (3% oxybenzone, 3% dioxybenzone)	7.0	5-10	23
SUNSWEPT (3.5% digalloyl trioleate)	7.0	5-10	23
ESTEE LAUDER (padimate)	6.5	5-8	16
UVAL (10% sulisobenzone)	6.5	6-9	16
AFIL (5% titanium dioxide, 5% menthyl anthrilinate)	6.5	6-8	16
PANULTRA (diphenylkerone)	6.0	4-7	17
PABAFILM (padimate)	6.0	4-9	23
SUNGARD (10% sulisobenzone)	6.0	4-8	16
SUNDARE (cinoxate)	6.0	4-8	16
BLOCK OUT (padimate)	5.5	4-7	16
PIZ BUIN 3 (methoxy-cinnamate, phenyl PHB ester)	4.5	4-6	15
COPPERTONE (9% homosalate)	3.5	3-5	15
RVP (red petrolatum)	3.0	2-4	18

The protection factor of 21 commercially available sunscreens applied in concentrations of 2 UL/cm² and tested at 305 nm (UVB) (4 nm half bandwidth).

RESULTS

The initial study with 305 nm radiation was performed with sunscreens marketed in 1977 and did not include Supershade 15. Presun had the highest SPF 13.5 and was more effective than the esters of PABA tested at that time; *ie,* Sea & Ski and Sundown in the range of 9-11. Sunscreens containing benzones; *ie,* Sol Bar, Uval, Panultra have a SPF in the range of 5-8 and were generally less effective for protection of sunburn UVB than the esters of PABA. The mean MED at 305 nm without sunscreen was 25.1 mWsec/cm² SD 7.6 mWsec/cm². The SPFs of the sunscreens tested at 305 nm are listed in approximate order of efficiency in Table 1.

The full spectral irradiation with the solar simulator was performed on selected sunscreens at a later date (1978/1979) and included Supershade 15 and Eclipse which rated high SPFs. The mean MED for the solar simulator was 35.0 mWsec/cm² SD 6.5 which compares with mean MED of 313 nm 37.0 mWsec/cm² SD 5.7 in action spectra studies.[1] There was no appreciable difference in testing with 305 nm or with the full spectrum solar simulator.

DISCUSSION

The sensitivity of skin to sunlight can be conveniently categorized into the four types:

SKIN TYPE		
I	*ALWAYS* BURN, *NEVER* TAN	ie: the celt, redhead, freckles, Irish-Scots
II	*ALWAYS* BURN, BUT *SOMETIMES* TAN	ie: fair-skinned, fair-haired, blue-eyed Caucasian
III	*SOMETIMES* BURN, *ALWAYS* TAN	ie: darker Caucasian
IV	*NEVER* BURN, *ALWAYS* TAN	ie: dark skin

Table 2—Sunscreen protection factor with solar simulator

SUNSCREEN	*Mean SPF*	*Range*	*No.*
SUPERSHADE (7% octyl-dimethyl PABA, 3% oxybenzone)	15.0	12-17	9
PRESUN (5% PABA)	13.0	12-16	24
ECLIPSE (5% octyl-dimethyl glyceryl PABA)	12.5	10-13	9
PIZ BUIN 6 (methoxy-cinnamate, benzophenone PHB ester)	11.0	9-13	9
SUNDOWN (3.3% octyl-dimethyl PABA)	8.5	7-11	18
MAXAFIL (4% cinoxate, 5% menthyl anthralinate)	8.5	7-10	24
SEA & SKI (4% isoamyl dimethyl PABA)	8.0	7-10	18
RVPaque (red petrolatum, zinc oxide, cinoxate)	7.5	6-9	24
UVAL (10% sulisobenzone)	7.0	6-8	18
SUNGARD (10% sulisobenzone)	6.0	5-7	20
PIZ BUIN 3 (methoxy cinnamate, phenylbenz, PHB ester)	4.5	4-5	18
COPPERTONE (9% homosalate)	3.5	3-5	24

The protection factor of 12 sunscreens applied in concentration of 2 UL/cm² tested with a filtered xenon arc solar simulator.

Sun damage to the skin can be simply equated as follows:

$$\text{sun damage} = \frac{\text{UV intensity X duration of exposure}}{\text{Nature of defense against damage}}$$

where nature of defense against damage can be represented by skin type and sunscreen. The UV intensity would depend on the ozone season, air mass, latitude, weather, and surface reflection. The duration of sun exposure would depend on age, sex, climate, occupation, amount of leisure time and the skin site such as the arms, hands, face and neck having the maximum exposure.

Based on these laboratory SPF determinations for sunscreens, it is proposed that the public could choose one of the available sunscreens most suited for their skin type and for their degree of sun exposure. For example, population with type I photosensitivity would be best suited for sunscreens with the highest PF, particularly if they were unavoidably spending an extended time in the sun, such as sailors, yachtsmen, and farmers, and could use Supershade 15, Presun, Pabanol or Eclipse and tan slowly. The darker Caucasian who rarely sunburns and who wishes to tan would be best suited for a sunscreen with a lower SPF; *ie,* Coppertone. Shown in Table 3 is a range of sunscreens suggested for use with the appropriate skin types. It is also strongly urged that manufacturers be responsible for labeling their products with a SPF value with an explanation of use with skin types. Available evidence suggests that sunlight plays a major role in the product of skin cancer and it is probable that sunscreens if regularly applied would lower the incidence.[4]

Table 3—Sunscreens for skin types

TYPE I SPF (12-16)
Supershade, Presun, Pabanol, Eclipse.

TYPE II SPF (8-12)
Piz Buin 6, Sundown, Sea & Ski, Maxafil.

TYPE III SPF (5-8)
RVPaque, Piz Buin 4, Uval, Sungard.

TYPE IV SPF (3-5)
Piz Buin 3, Coppertone, RVP (red petrolatum).

We have evaluated some sunscreens after bathing in a previous report,[8] but it should be reemphasized that this is a laboratory study and does not take into account environmental factors such as bathing or sweating or the varying concentration of application by the subject, so this study is just a guideline. It is, however, proposed to reevaluate the SPFs of sunscreens by testing under natural sunlight, but the nature of the varying intensity of sunlight would make this a comparative rather than an absolute protection factor.

In summary 23 commercially-available sunscreens were tested under comparable conditions and a protection factor was determined to be used with the appropriate skin type.

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Refer to: Amniotic fluid L/S ratio for fetal lung maturity; an update and review of new ideas. *Wisconsin Med J* 78: 33-34 (May) 1979

Key words: L/S ratio determinations, fetal pulmonary maturity, respiratory distress syndrome (RDS)

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Amniotic fluid L/S ratio for fetal lung maturity

An update and review of new ideas

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EDITORIAL NOTE: The use of the L/S ratio has been well established as an index of fetal pulmonary maturity. The accompanying article summarizes the experience with L/S ratio determinations at the University of Wisconsin Perinatal Center at Madison General Hospital, and discusses some newer modalities of assessing fetal pulmonary maturity.

THE USEFULNESS OF determining the amniotic fluid lecithin/sphingomyelin (L/S) ratio in predicting fetal pulmonary maturation and anticipating neonatal Respiratory Distress Syndrome (RDS) is well established. This remains an important aspect of perinatal care, since RDS still accounts for 2-3 deaths per 1000 live births in the state of Wisconsin. Also, about one-third of all neonatal intensive care admissions are due to RDS and several reports have appeared indicating there are many cases of iatrogenic RDS due to elective delivery by repeat Cesarean section or elective induction of a mother who has a baby with immature lungs.

Doctor Gluck's original report on the results of the amniotic fluid L/S ratio is nearly a decade old. In general, he found that when the L/S ratio of amniotic fluid had increased to greater than 2:1 there was very little chance of neonatal RDS. On the other hand, an L/S ratio of 1:1 indicated that probably RDS would be present if birth would occur at that time. Although the test is not without fault, it remains the most frequently used and the most reliable of all amniotic fluid tests for fetal lung maturity.

Results of the Madison program. The neonatal research laboratories at the Perinatal Center in Madison have been doing amniotic fluid L/S ratios for several years and periodically we have published these results. Our most recent summary, based on the known outcome of several hundred patients, is shown in Table 1. Note that the number for a very low chance of RDS in this laboratory is an L/S ratio greater than 3.5 in contrast to Doctor Gluck's original data of an L/S ratio greater than 2:1 as indicating maturity. However, the techniques from one laboratory to another might vary slightly so it is good for each laboratory to independently define their L/S ratio that gives a low incidence of RDS. There is probably no number that will be absolute, but a 99% certainty is a definite help in clinical practice. (A further breakdown for every 0.5 L/S is available.)

Some babies have RDS despite a mature L/S ratio. One reason for this can be laboratory error, but the chances of this are usually low because of the built-in controls. Another reason why neonatal RDS might occur despite a mature amniotic fluid L/S ratio is intrauterine or birth asphyxia. Two recent studies support this point. In one study, 33% of babies with L/S $>$ 2 but who were asphyxiated had RDS. No babies with L/S $>$ 2 and without asphyxia developed RDS. In the other study, infants with L/S $>$ 2 had six to eight times as much RDS when the APGAR was less than or equal to 6. Those with better APGAR scores and mature L/S ratios had less RDS. Inaccurate diagnosis of RDS could also be a reason for apparent RDS despite a mature amniotic fluid L/S. Diabetes in pregnancy has also been implicated as affecting the incidence of RDS in neonates born after amniotic fluid L/S ratios $>$ 2, but this data is being challenged recently by those studying neonatal outcome from well-controlled diabetic pregnancies.

Other amniotic fluid analyses for fetal lung maturation. Various other parameters of amniotic fluid have been assayed including total lipid, palmitic acid, total phospholipid, phospholipid

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phosphorus, total lecithin, phosphatidyl glycerol, surface tension, and certain enzymes. Investigators in each of these areas have established values they feel are predictive of the chance of RDS. However, it seems that none have proven better than the L/S ratio.

A method which is being advertised with enthusiasm recently is "fluorescent polarization." The basis of this approach is that the surface tension and microviscosity of amniotic fluid are related. As polarized light is passed through amniotic fluid lipids (containing a probe that absorbs polarized light) the light is changed depending on the microviscosity of the amniotic fluid. The claimed advantages of this method are that the polarization value reflects the microviscosity of the whole lipid assembly of amniotic fluid, not just lecithin. This, the proponents of this system say, is more related to the surface distending ability of the lung than merely determining the L/S ratio. The method is also simpler than determining L/S ratios since the analysis itself can be done in about ten minutes compared to two to three hours for an L/S ratio. There are two or three recent reports claiming accurate predictability of RDS in neonates based on fluorescent polarization studies of amniotic fluid. The problems with this system thus far include: (a) little data on fetuses and neonates of less than 36-week gestations, (b) the samples can bleach in ultraviolet light, and, (c) freezing and thawing of samples alters results. It is also unclear how significant the changes are with gestational age. Since the instrument for these analyses costs in the range of $13,000 to $15,000, it seems appropriate to await further comparisons of fluorescent polarization and neonatal outcome before switching from the L/S ratio determinations.

Of recent interest also is the prediction of fetal lung maturity based on the presence of phosphatidyl glycerol (PG) in the amniotic fluid. A report shows that as gestation approaches to term, the percentage of phosphatidyl glycerol increases markedly after 36 weeks gestation. In addition, investigators report that the tracheal effluent of healthy newborns at term had about 5% of the lipid phosphorus as PG but in babies with RDS the PG was absent. This lead to some interest in attempting to determine whether PG was a more reliable indicator of RDS than the L/S ratio. To date, however, it is not apparent that very many investigators or hospitals have had extensive experience with this analysis of PG and its correlation with L/S ratio in the incidence of RDS. Therefore, again, it seems best to await further studies on this parameter before the test is adopted for widespread use.

Table 1—The incidence of neonatal RDS vs the amniotic fluid L/S ratio*

	% RDS (DEATH)	
L/S	Born ≤ 2 days after amniocentesis	Born ≤ 7 days after amniocentesis
< 2.5	45 (27.0)	20 (13.0)
2.5 - 3.4	10.5 (3.5)	9.4 (1.7)
≥ 3.5	1.4 (0.23)	1.1 (0.16)

*Data from the Neonatal Research Laboratory, Southcentral Region Perinatal Center, Madison, up to 9/1/78.

Summary. The amniotic fluid L/S ratio as a predictor of the chances of neonatal RDS has been used for the past several years. There are several reasons neonatal RDS could develop despite a "mature L/S." Such factors include perinatal asphyxia, laboratory error, absence of phosphatidyl glycerol, improper fatty acids on the lecithin molecule, and so forth. It is obvious that there is need for fetal pulmonary maturation determinations. Use of this parameter by the practitioners in Wisconsin can cut down on the incidence and neonatal deaths from RDS. Newer methods for evaluation of fetal lung maturity still need to be time-tested before their general use can be advocated. ■

Abstracts

Gonorrhea in adolescents: Complement-fixing antibodies in a selected population of young women

Hania W Ris, MD and Robert C Blaken, PhD, University of Wisconsin Medical School, Madison, Wis; and Bio-Science Laboratories, Van Nuys, CA: *Sexually Transmitted Diseases* 4:81-83 (Jul-Sept) 1977

Over a four-year period a group of 209 young women committed to a state institution for delinquent youths was screened for infection with *Neisseria gonorrhoeae* by multiple bacteriologic cultures and by gonococcal complement-fixation tests. In this selected population of sexually active young women with a relatively high prevalence of gonorrhea, the gonococcal complement-fixation test proved too insensitive to justify primary reliance on it for the identification of cases of actual disease. Only 25 (38%) of infected women had reactive sera. The specificity of the test was somewhat better; in two cases unexpected seropositivity led to the identification and treatment of previously-missed asymptomatic disease. ■

Special to the Journal

GONORRHEA: Recommendations for the treatment of uncomplicated and complicated gonococcal infections

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL
ATLANTA, GEORGIA

CDC recommended treatment schedules, 1978

NOTE: Physicians are cautioned to use no less than the recommended dosages of antibiotics

UNCOMPLICATED GONOCOCCAL INFECTIONS IN MEN AND WOMEN

Drug Regimens of Choice:

Aqueous procaine penicillin G (APPG) 4.8 million units injected intramuscularly at two sites, with 1.0 g of probenecid by mouth.

or

Tetracycline hydrochloride* 0.5 g by mouth 4 times a day for 5 days (total dosage 10.0 g). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as a single-dose therapy.

or

Ampicillin 3.5 g, or amoxicillin 3.0 g, either with 1 g probenecid by mouth. Evidence shows that these regimens are slightly less effective than the other recommended regimens.

Patients who are allergic to the penicillins or probenecid should be treated with oral tetracycline as above. Patients who cannot tolerate tetracycline may be treated with spectinomycin hydrochloride 2.0 g in one intramuscular injection.

Special Considerations:

- Single-dose treatment is preferred in patients who are unlikely to complete the multiple-dose tetracycline regimen.
- The APPG regimen is preferred in men with anorectal infection.

*Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

The recommendations in this article were established after deliberation with these therapy consultants:

1. Harold C. New, M.D., College of Physicians and Surgeons, Columbia University;
2. Erwin H. Braff, M.D., San Francisco Department of Public Health;
3. Gary Cunningham, M.D., Southwestern Medical School, Dallas;
4. King K. Holmes, M.D., Ph.D., USPHS Hospital, Seattle;
5. Franklyn Judson, M.D., Department of Health and Hospitals, Denver;
6. William McCormack, M.D., State Laboratory Institute, Boston;
7. Edwin M. Mears, Jr., M.D., New England Medical Center, Boston;
8. John D. Nelson, M.D., Southwestern Medical School, Dallas;
9. Morton Nelson, M.D., Orange County, California
10. Suzanne M. Sgroi, M.D., Suffield, Conn.;
11. Frederick Sparling, M.D., School of Medicine, The University of North Carolina, Chapel Hill;
12. Lt. Col. Edmund C. Tramont, Walter Reed Army Medical Center, Washington, D.C.

- Pharyngeal infection is difficult to treat: high failure rates have been reported with ampicillin and spectinomycin.

- Tetracycline treatment results in fewer cases of postgonococcal urethritis in men.

- Tetracycline may eliminate coexisting chlamydial infections in men and women.

- Patients with incubating syphilis (seronegative, without clinical signs of syphilis) are likely to be cured by all the above regimens except spectinomycin. All patients should have a serologic test for syphilis at the time of diagnosis.

- Patients with gonorrhea who also have syphilis or are established contacts to syphilis should be given additional treatment appropriate to the stage of syphilis.

Treatment of Sexual Partners:

Men and women exposed to gonorrhea should be examined, cultured and treated at once with one of the regimens above.

Follow-up:

Follow-up cultures should be obtained from the infected site(s) 3-7 days after completion of treatment. Cultures should be obtained from the anal canal of all women who have been treated for gonorrhea.

Treatment Failures:

The patient who fails therapy with penicillin, ampicillin, amoxicillin, or tetracycline should be treated with 2.0 g of spectinomycin intramuscularly.

Most recurrent infections after treatment with the recommended schedules are due to *reinfection* and indicate a need for improved contact tracing and patient education. Since infection by penicillinase (β-lactamase)-producing *Neisseria gonorrhoeae* is a cause of treatment failure, posttreatment isolates should be tested for penicillinase production.

Not Recommended:

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have NO place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

PENICILLINASE-PRODUCING NEISSERIA GONORRHOEAE (PPNG)

Patients with uncomplicated PPNG infections and their sexual contacts should receive spectinomycin 2.0 g intramuscularly in a single injection. Because gonococci are very rarely resistant to spectinomycin and reinfection is the most common cause of treatment failure, patients with positive cultures after spectinomycin therapy should be re-treated with the same dose.

A PPNG isolate that is resistant to spectinomycin may be treated with cefoxitin 2.0 g in a single intramuscular injection, with probenecid 1.0 g by mouth.

TREATMENT IN PREGNANCY

All pregnant women should have endocervical cultures for gonococci as an integral part of the prenatal care at the time of the first visit. A second culture late in the third trimester should be obtained from women at high risk for gonococcal infection.

Drug regimens of choice are APPG, ampicillin or amoxicillin, each with probenecid as described above.

Women who are allergic to penicillin or probenecid should be treated with spectinomycin.

Refer to the section on acute salpingitis and disseminated gonococcal infections for the treatment of these conditions during pregnancy. Tetracycline should not be used in pregnant women because of potential toxic effects for mother and fetus.

ACUTE SALPINGITIS (PELVIC INFLAMMATORY DISEASE)

There are no reliable clinical criteria on which to distinguish gonococcal from nongonococcal salpingitis. Endocervical cultures for *N. gonorrhoeae* are essential. Therapy should be initiated immediately.

Hospitalization should be strongly considered in these situations:

1. Uncertain diagnosis, in which surgical emergencies such as appendicitis and ectopic pregnancy must be excluded.
2. Suspicion of pelvic abscess.
3. Severely ill patients.
4. Pregnancy.
5. Inability of the patient to follow or tolerate an outpatient regimen.
6. Failure to respond to outpatient therapy.

Antimicrobial Agents:

Outpatients:

Tetracycline* 0.5 g taken orally 4 times a day for 10 days. This regimen should not be used for pregnant patients.

or

APPG 4.8 million units intramuscularly, ampicillin 3.5 g or amoxicillin 3.0 g each with probenecid 1.0 g. Either regimen is followed by ampicillin 0.5 g or amoxicillin 0.5 g orally 4 times a day for 10 days.

Hospitalized patients:

Aqueous crystalline penicillin G 20 million units given intravenously each day until improvement occurs, followed by ampicillin 0.5 g orally 4 times a day to complete 10 days of therapy.

or

Tetracycline* 0.25 g given intravenously 4 times a day until improvement occurs, followed by 0.5 g orally 4 times a day to complete 10 days of therapy. This regimen should not be used for pregnant women. The dosage may have to be adjusted if renal function is depressed.

Since optimal therapy for hospitalized patients has not been established, other antibiotics in addition to penicillin are frequently used.

Special Considerations:

- Failure of the patient to improve on the recommended regimens does not indicate the need for stepwise additional antibiotics but requires clinical reassessment.

- The intrauterine device is a risk factor for the development of pelvic inflammatory disease. The effect of removing an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis is unknown.

- Adequate treatment of women with acute salpingitis must include examination and appropriate treatment of their sex partners because of their high prevalence of nonsymptomatic urethral infection. Failure to treat sex partners is a major cause of recurrent gonococcal salpingitis.

- Followup of patients with acute salpingitis is essential during and after treatment. All patients should be recultured for *N. gonorrhoeae* after treatment.

ACUTE EPIDIDYMITIS

Acute epididymitis can be caused by *N. gonorrhoeae, Chlamydia* or other organisms. If gonococci are demonstrated by Gram stain or culture of urethral secretions, treatment should be:

APPG 4.8 million units, ampicillin 3.5 g or amoxicillin 3.0 g, each with probenecid 1.0 g. Either regimen is followed by ampicillin 0.5 g or amoxicillin 0.5 g orally 4 times a day for 10 days.

or

Tetracycline* 0.5 g orally 4 times a day for 10 days.

If gonococci are not demonstrated, the above tetracycline regimen should be used.

DISSEMINATED GONOCOCCAL INFECTION

Equally effective treatment schedules in the arthritis-dermatitis syndrome include:

Ampicillin 3.5 g or amoxicillin 3.0 g orally, each with probenecid 1.0 g, followed by ampicillin 0.5 g or amoxicillin 0.5 g 4 times a day orally for 7 days.

or

Tetracycline* 0.5 g orally 4 times a day for 7 days. Tetracycline should not be used for complicated gonococcal infection in pregnant women.

or

Spectinomycin 2.0 g intramuscularly twice a day for 3 days (treatment of choice for disseminated infections caused by PPNG).

or

Erythromycin 0.5 g orally 4 times a day for 7 days.

or

Aqueous crystalline penicillin G 10 million units intravenously per day until improvement occurs, followed by ampicillin 0.5 g 4 times a day to complete 7 days of antibiotic treatment.

Special Considerations:

- Hospitalization is indicated in patients who may be unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.

- Open drainage of joints other than the hip is not indicated.

- Intra-articular injection of antibiotics is unnecessary.

Meningitis and endocarditis caused by the gonococcus require high-dose intravenous penicillin therapy. In penicillin-allergic patients with endocarditis, desensitization and administration of penicillin is indicated; chloramphenicol may be used in penicillin-allergic patients with meningitis.

GONOCOCCAL INFECTIONS IN PEDIATRIC PATIENTS

With gonococcal infections in children beyond the newborn period the possibility of sexual abuse must be considered. Genital, anal and pharyngeal cultures should be obtained from all patients before antibiotic treatment. Appropriate cultures should be obtained from individuals who have had contact with the child.

PREVENTION OF GONOCOCCAL OPHTHALMIA

When required by State legislation or indicated by local epidemiologic considerations, effective and acceptable regimens for prophylaxis of neonatal gonococcal ophthalmia include:

Ophthalmic ointment or drops containing tetracycline or erythromycin.

or

One per cent silver nitrate solution.

Special Considerations:

- Bacitracin is not recommended.
- The value of irrigation after application of silver nitrate is unknown.

MANAGEMENT OF INFANTS BORN TO MOTHERS WITH GONOCOCCAL INFECTION

The infant born to a mother with gonorrhea is at high risk of infection and requires treatment with a single intravenous or intramuscular injection of aqueous crystalline penicillin G 50,000 units to full-term infants or 20,000 units to low-birth-weight infants. Topical prophylaxis for neonatal ophthalmia is not adequate treatment. Clinical illness requires additional treatment.

NEONATAL DISEASE

Gonococcal Ophthalmia: Patients should be hospitalized and isolated for 24 hours after initiation of treatment. Untreated gonococcal ophthalmia is highly contagious. Aqueous crystalline penicillin G 50,000 units/kg/day in 2 doses intravenously should be administered for 7 days. Saline irrigation of the eyes should be performed as needed. Topical antibiotic preparations alone are not sufficient or required when appropriate systemic antibiotic therapy is given.

Complicated Infection: Patients with arthritis and septicemia should be hospitalized and treated with aqueous crystalline penicillin G 75,000 to 100,000 units/kg/day intravenously in 2 or 3 divided doses for 7 days. Meningitis should be treated with aqueous crystalline penicillin G 100,000 units/kg/day, divided into 3 or 4 intravenous doses, and continued for at least 10 days.

CHILDHOOD DISEASE

Children who weigh 100 lbs. (45 kg) or more should receive adult regimens. Children who weigh less than 100 lbs. should be treated as follows:

Uncomplicated Disease:

Uncomplicated vulvovaginitis, urethritis, proctitis or pharyngitis can be treated at one visit with:

Amoxicillin 50 mg/kg orally with probenecid 25 mg/kg (maximum 1.0 g).

or

Aqueous procaine penicillin G 100,000 units/kg intramuscularly plus probenecid 25 mg/kg (maximum 1.0 g).

Special Considerations:

- Topical and/or systemic estrogen therapy are of no benefit in vulvovaginitis.
- Long-acting penicillins, such as benzathine penicillin G, are not effective.
- All patients should have follow-up cultures and the source of infection should be identified, examined and treated.

Gonococcal Ophthalmia:

Ophthalmia in children is treated as in neonates but the dose of penicillin is increased to 100,000 units/kg/day intravenously.

Complicated Infections:

Patients with peritonitis or arthritis require hospitalization and treatment with aqueous crystalline penicillin G, 100,000 units/kg/day intravenously for 7 days. Aqueous crystalline penicillin G 250,000 units/kg/day intravenously in 6 divided doses for at least 10 days is recommended for meningitis.

Allergy to Penicillins:

Children who are allergic to penicillins should be treated with spectinomycin 40 mg/kg intramuscularly. Children older than 8 years may be treated with tetracycline 40 mg/kg/day orally in 4 divided doses for 5 days. For treatment of complicated disease, the alternative regimens recommended for adults may be used in appropriate pediatric dosages. ■

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n 87% of patients studied [303 of 349], zo Gantanol® reduced ain and/or burning within 24 hours*

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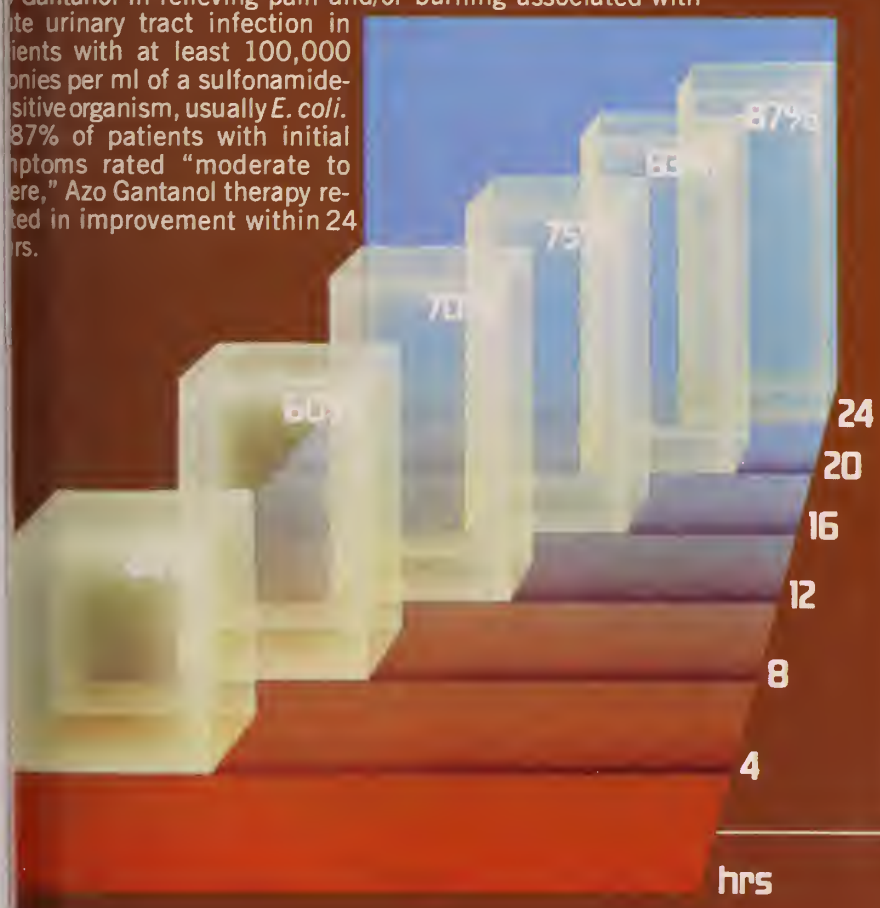

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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A reminder

ZYLOPRIM®

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets bottles of 100 and 1000; 300 mg (peach) scored tablets bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.
Parenteral administration is not recommended in the presence of hypotension or tachycardia.
Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.
Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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When painful spasm is the presenting symptom...

...in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.

Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INOICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective:
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL OISOROERS ARE OFTEN RELIEVEO BY VARYING COMBINATIONS OF SEOATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. AOVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. OOSAGE ANO AOMINISTRATION: Oosage must be adjusted to individual patient's needs.
Usual Dosage. Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Oecatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Oivision ot Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U S A

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Socety.

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CIRCULATION. Members of the State Medical Society of Wisconsin receive the WISCONSIN MEDICAL JOURNAL each month. The cost of the Journal for members ($6.00 per year) is included in dues. Non-members may subscribe at the following rates: $12.00, one year; $1.50, single copy; $3.00, previous years; $5.00, Annual Blue Book. The JOURNAL reserves the right to control its circulation.

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

UW to treat breast cancers with interferon

RECENTLY THE Wisconsin Clinical Cancer Center in Madison was designated by the American Cancer Society as one of nine US medical institutions to be given interferon to test in 100-150 human cancer patients.

Interferons are cell glycoproteins which are synthesized in response to viral infections and nonviral inducers. They are species specific, so human interferon must be used in studies done on humans. There are three types of interferon: leukocyte interferon, fibroblast interferon, and immune interferon produced by lymphocytes in response to mitogens or antigens. Leukocyte interferon will be used in the planned clinical studies. Interferons are among the most potent, biologically active compounds known, showing activity in amounts of about 10^{-8} M.

The mechanism of antitumor action of interferons remains under investigation. Binding to membrane gangliosides seems to be necessary for antiviral action. Interferons inhibit both viral and nonviral induced animal tumors, oncogenic viruses, and the multiplication of both normal and transformed cells in vitro.

Interferons increase lymphocyte cytotoxic responses but depress lymphocyte proliferation in response to mitogens and allogeneic lymphocyte and B cell function, both in vitro and in vivo. They also enhance macrophage activity and may alter target cells. In patients human leukocyte interferon does not cause depression of antibody responses.

No major toxicities or histological abnormalities have been observed when humans have been treated with interferon. When given intramuscularly, there may be local erythema and discomfort at the injection site but no ulcerations or crusting. Almost all of the treated patients have had a fever of 38-40 C which has disappeared with continued administration. Reversible leukopenia and thrombocytopenia have been observed.

Because of difficulties in producing adequate amounts of interferon for clinical trial, only a few clinical studies have been performed. When interferon was used as an adjuvant for primary management of osteosarcoma of the long bone, survival increased; the results have been equivalent to those obtained with high dose methotrexate and adriamycin. Patients with nodular poorly differentiated lymphocytic lymphoma, Hodgkin's disease, and multiple myeloma have all had objective responses. In a study of 14 women with metastatic breast cancer treated systemically with leukocyte interferon, six had partial responses of from six weeks to more than eight months duration.

Dr Ernest C Borden of the Wisconsin Clinical Cancer Center and the Veterans Administration Hospital in Madison has been named principal investigator and given enough interferon to treat about ten women with breast cancer. The cost of the drug will be about $13,000 for each patient. Therefore, treatment of patients will be limited to those women with objectively measurable breast carcinoma which has metastasized to the lymph nodes, cutaneous tissue, or lungs; who are on no concurrent therapy; who have a good performance status; and who have not had significant amounts of previous systemic therapy for the metastatic disease. The women selected to receive interferon will be given intramuscularly 3 x 10^6 units of interferon daily for one month. Responding patients will be continued on therapy for an additional defined period. Physicians having patients considered eligible for interferon, can reach Doctor Borden at 608/263-1761 if they wish further details concerning eligibility or the treatment program.

Interferons may not be the panacea for all cancer, but they are completely different from the chemotherapeutic drugs now in use. It is hoped that these studies and those being conducted at the other institutions designated by the American Cancer Society will either confirm or refute the antitumor efficacy of interferon in man.—DOROTHY J BUCHANAN-DAVIDSON, PhD, Science Writer, WCCC ■

MEDICINE OR BUSINESS?

If you're like most physicians, you're spending more hours working each month before the dollars you earn are your own. Just about everything you need to practice medicine is increasing in cost at an alarming rate.

If you feel you're practicing business instead of medicine, why not consider an alternative? Medicine can still be a great way of life — with reasonable hours, opportunities for specialization, and emphasis on patient care instead of paperwork.

Air Force medicine may be an exciting alternative for your future.

We would like to tell you more — about the 30 days of paid vacation each year, about our opportunities for specialization, and our excellent compensation package.

Contact Capt. Tom Skalemenos, Suite 204, 2457 N. Mayfair Rd., Wauwatosa, WI 53226 (414) 258-2430 — Collect.

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Telephone: (Area Code 414) 784-3780

Physicians Alliance

Editor: BRIAN JENSEN
Director: Physicians Alliance Division

GOVERNMENTAL AFFAIRS

Committee supports Radiation Council restructuring

The State Medical Society's Commission on Governmental Affairs April 11 endorsed legislation which restructures the Radiation Protection Council and broadens the Council's powers and duties.

The action was recommended by the Society's Committee on Environmental Health, a body established in late 1977 to assist the Society in responding to problems dealing with health and the environment.

The proposal, Assembly Bill 209 would increase the membership of the Council from 9 to 17 members, eight to be representatives of state agencies and the remaining nine to be public members appointed by the Governor. Public members are to represent a balance of medical, economic, scientific, and environmental viewpoints.

The legislation is intended to promote communication among agencies involved with radiation-related issues and will enable the Council to monitor all private, state, and federal radiation policies and programs.

The Commission also recommended that the legislation specifically include a radiation physicist involved in health care and a hematologist or oncologist from the medical community to represent medical viewpoints on the Council. The physicians suggested that the Department of Agriculture be included as an agency representative to offer expertise on the effects of radiation on the food chain.

The Commission's action does not come in response to the recent accident at Three Mile Island Nuclear Power Plant in Pennsylvania; the SMS Committee on Environmental Health has been considering proposals resulting from the Legislative Council's Subcommittee on Radioactive Waste Management for several months. ■

Fetal alcohol syndrome, midwifery legislation considered

In other action April 11, the Governmental Affairs Commission (GAC) considered a proposal introduced by Rep Sharon Metz (D-Green Bay) that would require fetal alcohol syndrome (FAS) warning labels be placed on alcoholic beverage containers and display signs be posted in establishments selling alcoholic beverages.

Rep Metz, appearing before the Commission, said the intent of the legislation is to help bring the issue of fetal alcohol syndrome and its dangers to the public's attention.

After considerable discussion, the Commission decided not to take a formal position on the bill but to endorse language contained in a progress report by the Federal Bureau of Alcohol, Tobacco, and Firearms which states: ". . . that there is a need for a public awareness campaign which educates the public about the possible dangers that consumption of liquor, beer and wine by a pregnant woman can present to an unborn child. Because of the nature of the evidence now available as to the possible dangers, it is not yet clear that warning labels on alcoholic beverage containers would be the best tool to educate the public . . ."

The Commission also recommended changes in Assembly Bill 66, which proposes to establish a nurse-midwife program in Wisconsin. The Commission saw a major problem in the legislation's definition of "physician supervision" of a nurse-midwife.

Presently, the legislation states that "physician supervision" does not necessarily mean the physical presence of a physician. The Commission will recommend an amendment to the Legislature to delete this sentence. The Commission stated that the decision to require physical presence of a physician should be made by the individual physician. ■

—DIANE UPTON, Communications Dept

Organizational SMS

Physician group joins Specialty Services Program

The Wisconsin Council on Child and Adolescent Psychiatry recently agreed to become part of the State Medical Society's Specialty Services Program. Under the agreement, the Society will provide certain administrative and executive services to the Council at minimal cost and appoint Bill Wendle of the SMS staff to serve as executive secretary for the Council.

The Wisconsin Council of Child and Adolescent Psychiatry is the first physician group to enter into the Society's Specialty Services Program, designed to help unify the many components of medical practice while at the same time aid the membership of individual specialty associations. For more information contact Bill Wendle at the SMS Health Services Division. ■

Lose your license?

You could . . . if you fail to report your continuing medical education credits to the State Medical Examining Board by December 1, 1979. State law requires all licensed physicians to submit proof to the Board of 30 hours of Category I continuing medical education credit. Any physician failing to report CME credits by December 1, 1979 will not receive a license renewal notice for 1980-81.

Category I CME credits accumulated since January 1, 1977 can be reported. A receipt from the sponsoring organization indicating its name, your name, the number of hours completed, and Category I approval by either the AMA or the AOA is required. Proof of CME credits must be sent by December 1, 1979 to:

State Medical Examining Board
1400 East Washington Avenue
Madison, Wisconsin 53703

. . . or you won't have a license to practice medicine in 1980. If you have questions or concerns, call the State Medical Society Health Services Division: 608/257-6781 (Madison area) or toll-free 1-800/362-9080. ■

Medical Museum reopens May 1—Labor Day

Wisconsin citizens and visitors can enjoy an opportunity to learn more about medical history by visiting the Fort Crawford Military Hospital at the Museum of Medical Progress in Prairie du Chien beginning May 1 when the museum opened its doors for the 1979 season.

Located on the site of the reconstructed Fort Crawford military hospital, which is now a national historic landmark, the Museum of Medical Progress is set in the picturesque Mississippi River Valley in Prairie du Chien. Its rooms capture the fort physician and the "horse and buggy" doctor of days past.

The museum is dedicated to the memory of Dr William Beaumont, a military surgeon, who in the early 1830s performed a series of abdominal experiments on a young voyageur named Alexis St Martin. These studies formed the basis of present day knowledge of the digestive system.

Events that shaped the course of surgical history are depicted in dioramas at the Fort Crawford Museum. These dioramas depict early operations—amputations done without anesthetics, and pioneer milestones in surgery.

Visitors to Fort Crawford will see an oldtime dentist's office including all the equipment the 19th century dentist had available to him to use in his practice, and a refurbished pharmacy including the actual 1890s prescriptions and the instruments used to prepare them.

Built in 1831, the Fort Crawford Military Hospital site was originally acquired by the Prairie du Chien Chapter of the Daughters of the American Revolution in 1921 and finally restored in 1959 by Wisconsin physicians through

continued on page 50

For hemorrhoids and other anorectal conditions

External hemorrhoids

Internal hemorrhoids

Pruritus ani

Proctitis

Anal fissures

Easy to handle, easy to insert, comfortably shaped—Rx only

Easy to apply, nonstaining—Rx only

Prescribe

Anusol-HC®

Suppositories/Cream

for symptomatic relief

- Effectively reduces inflammation and edema
- Rapidly relieves pain and itching

ANUSOL-HC® SUPPOSITORIES
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ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
CAUTION: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2.25%, bismuth resorcin compound, 1.75%, benzyl benzoate, 1.2%, Peruvian balsam, 1.8%, zinc oxide, 11.0%, also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01); with plastic applicator, detachable label.

Store between 15°-30° C (59°-86° F).

Full information is available on request.

Warner/Chilcott
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

AN-GP-91

The professional source of anorectal comfort

the Society's Charitable, Educational and Scientific Foundation.

Located at 717 Beaumont Road, the museum will be open daily this year from May 1 through Labor Day, 10 am to 5 pm. Admission is $1.00 for adults, 50¢ for children. There is no admission charge to SMS physicians and their families.

The museum's operating expenses are subsidized through funds appropriated by the State Medical Society which is seeking other financial support to create an endowment fund to cover future expenses. The museum was closed in 1977, reopened on a limited basis in 1978, and in 1979 opened on a full schedule. ■

1978 record year for SMS membership

The SMS Membership Department reports that 1978 was a record year for recruiting new members to the State Medical Society of Wisconsin. In 1978 there was a net increase of 119 new members, more than three times as many as the average yearly increase. SMS had 4605 members by year-end 1978. ■

SMS annuity unit value: $2.58

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians, was $2.58 as of March 30, 1979. ■

—DIANE UPTON, Communications Dept

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1979

3 Dane County Medical Society Board of Trustees
4 Health Care Coalition
5 WisPRO Field Operations Staff Meeting
5 University of Wisconsin Medical School Preceptors
6 WisPRO Review and Evaluation Committee
6 WisPRO Field Operations Staff Meeting
6 SMS Services, Inc
6 Executive Committee of SMS Council (Madison)
7 Finance Committee of SMS Council
7 SMS Council
10 Dane County Medical Society General Membership (Madison)
11 SMS Committee on Federal Legislation
11 SMS Commission on Governmental Affairs
11 SMS Committee on Environmental Health
11 Physicians Task Force-Health Planning Council Area 1
11 Wisconsin Clinic Managers, Department of Health and Social Services
17 Madison Society of Obstetrics-Gynecology
19 WisPRO Ancillary Services Review Committee
19 Wisconsin Immunization Initiative Coordinating Committee
20 SMS Committee on Mental Health
20 SMS Physicians Alliance Commission
25 WisPRO Advisory Group
25 WisPRO Medical Care Evaluation Committee
26 SMS Commission on Peer Review
26 WisPRO South Central District Review Council
27 SMS Commission on Continuing Medical Education
27 WisPRO Continuing Medical Education
29 Second Councilor District Caucus

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

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Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of March 9, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/subspecialty)

County Medical Society

ASHLAND-BAYFIELD-IRON

Krutsch, Kenneth N, Route 2, Washburn 54891 (1944, Regular, Urology)
Saarinen, David M, 2101 Beaser Ave, Ashland 54806 (1949, Regular, Family Physician)

BROWN

Amarnani, Narayan H, 430 S Webster Ave, Green Bay 54301 (1947, Regular, Gastroenterology/Internal Medicine)
Bauer, Mark A, 704 S Webster Ave, Green Bay 54301 (1947, Regular, Orthopedic Surgery)
Horak, Richard D, 118 N Monroe, Green Bay 54301 (1944, Regular, Orthopedic Surgery)
Korger, Dennis M, 1751 Deckner Ave, Green Bay 54302 (1944, Regular, Pediatrics)
Poley, Carl R, 1821 S Webster Ave, Green Bay 54301 (1945, Regular, Obstetrics and Gynecology, Certified)

DANE

Churchill, Melvin Jr, 30 S Henry St, Madison 53703 (1947, Regular, Rheumatology/Internal Medicine, Certified-IM)
Dodson, Vernon N, 3005 Post Rd, Madison 53713 (1923, Regular, Occupational Medicine/Internal Medicine, Certified-IM)
Kalin, Ned H, 1050 Spaight St, Madison 53703 (1951 Resident, Psychiatry)

MILWAUKEE

Chintamaneni, Jagan, 2388 N Lake Dr, Milwaukee 53211 (1938, Regular, Internal Medicine/Cardiovascular Diseases)
Hodach, Richard J, 4313 N Prospect Ave, Shorewood 53211 (1943, Resident, Neurology)
Karnes, Mack A, 5900 S Lake Dr, Cudahy 53110 (1946, Regular, Radiology, Certified)
Tolson, Lawrence S, 3822 N 55th St, Milwaukee 53216 (1946, Resident, Internal Medicine)
Vattakattcherry, G C, 2388 N Lake Dr, Milwaukee 53211 (1944, Regular, Pediatrics)
Waitzman, Jeffrey S, 8584 W Appleton Ave, #20, Milwaukee 53225 (1946, Resident, Obstetrics and Gynecology)
White, James E, 9516 Harding Blvd, Wauwatosa 53226 (1947, Resident, Plastic Surgery/General Surgery, Certified-GS)

OUTAGAMIE

Tatlock, Thomas W, 610 E Longview Dr, Appleton 54911 (1942, Regular, Psychiatry)

PIERCE-ST CROIX

Hanson, Bruce G, 661 Parkview Dr, New Richmond 54017 (1949, Regular, Family Physician, Certified)
Hastings, Vicki L, 220 Vine St, Hudson 54016 (1949, Regular, Family Physician)
Johnson, Robert B Jr, 409 Spruce St, River Falls 54022 (1948, Regular, Family Physician, Certified)

RACINE

Gierahn, James P, 2405 Northwestern Ave, Racine 53404 (1949, Regular, Internal Medicine)

TREMPEALEAU-JACKSON-BUFFALO

Martin, W Bradford, 1933 Park St, Whitehall 54773 (1944, Regular, General Surgery/Family Physician)

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WOOD

Koch, Edgar L, Marshfield, to 727 Kenney Ave, Eau Claire 54701

DEATHS

Vingom, Clair O, Dane County, Feb 11, 1979
Molsberry, Jasper M, Milwaukee County, Feb 12, 1979
Peck, Donald D, Winnebago County Feb 12, 1979
Zantow, Forrest E, Oconto County, Feb 12, 1979 ▪

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Obituaries

◈County, State, AMA Members

◈ **Ernest O Henschel, MD,** 58, professor and chairman of anesthesiology at the Medical College of Wisconsin, Milwaukee, died Feb 1, 1979 in Oconomowoc: Further details, as released by the Medical College of Wisconsin, appear below.

◈ **Elwood W Mason, MD,** 75, Milwaukee area physician for more than 40 years, died Feb 4, 1979 in Milwaukee. Born July 27, 1903 in Burton, Mich, he graduated from the University of Michigan Medical School in 1930. He joined the medical staff of Columbia Hospital in 1936 and was chairman of the Department of Medicine there from 1946 to 1958. He also served as chief-of-staff at Columbia Hospital from 1958 to 1966. An assistant clinical professor at the Medical College of Wisconsin, Doctor Mason was a member of the American College of Physicians, Milwaukee Academy of Medicine, and the Milwaukee Surgical Society.

Ernest O Henschel, MD: 1921-1979

Dr Ernest Henschel, who died February 1, 1979 at Memorial Hospital in Oconomowoc, headed programs in anesthesiology for the Medical College from 1966 until his death. He was director of anesthesiology, operating and recovery room services at Milwaukee County Medical Complex, and chief of the anesthesia service at the Veterans Administration Center, Wood, Wisconsin.

A leader in his profession, Doctor Henschel was known internationally. His contributions to his field included investigations for improved methods for the delivery of anesthesia and for avoiding complications from anesthetics during surgery and postoperatively.

Dr Henschel

Doctor Henschel was responsible for increasing the awareness among anesthesiologists of malignant hyperthermia. The condition is particularly common in Wisconsin and the Midwest, although it occurs throughout the world. Doctor Henschel was in the process of establishing a registry of such patients in Wisconsin as a preventive measures and of seeking a predictive test for carriers of the disease.

He conducted studies in electro-anesthesia and electro-sleep to determine the possibilities for use as alternatives to traditional anesthesia and for relief of chronic pain.

"Doctor Henschel will be remembered for his persistence and foresight in dealing with the problems of illness, including his own," said Edward J Lennon, MD, dean of the Medical College. "He presaged the decline of his own ability to function to the day. He asked that he be relieved of his duties as chairman, effective February 1."

"Because of his dual training in internal medicine and anesthesiology, he brought unique insights to his field and to this school," Doctor Lennon said. "Under his direction, the Medical College was among the first schools to include anesthesiology as a required academic study for its students," Doctor Lennon said in paying tribute to Doctor Henschel.

Doctor Henschel was born in Vienna, Austria, Jan 29, 1921. He became an American citizen in 1960. His medical studies were repeatedly interrupted at the University of Vienna, University of Freiburg, and the University of Prague during World War II when he served as a medical officer in the German navy. He received his MD degree from Charles University, Prague, in 1945.

He took postgraduate studies at universities in Switzerland; Wales, England; and Canada in internal medicine and subsequently in pulmonary disease.

Doctor Henschel's association with the Medical College began as a resident physician in internal medicine at Milwaukee County General Hospital, 1957-59. Following was a residency in anesthesiology at the VA Hospital, Wood, 1960-62, and a postgraduate fellowship in anesthesiology at Columbia Presbyterian Medical Center, New York City, 1962-63.

Doctor Henschel returned to Milwaukee in 1963. He was responsible for establishing the anesthesiology service and the Anesthesiology Research Laboratory at the Wood VA Hospital. He was director of research for the department from 1963-67, relinquishing those duties after he became chairman in 1966.

Doctor Henschel was a director of the American Board of Anesthesiology and held positions in numerous other societies. He was certified in internal medicine and in anesthesiology by the Royal College of Physicians and Surgeons, Canada; was a fellow of the American College of Anesthesiologists, the American College of Chest Physicians, and the American College of Physicians.

Doctor Henschel has produced over 30 publications and four books. Of special mention are the following: The Guillain-Barre Syndrome. A Personal Experience, *Anesthesiology* 47:228-231, 1977; and editor of *Malignant Hyperthermia—Current Concepts,* Appleton-Century-Crofts, 1977.

He is survived by his widow, Ann Bardeen, MD, Oconomowoc, and two daughters, Ingrid and Kira; as well as other relatives. ■

Surviving are his widow, Mary; two sons, John Mason, MD, Hinsdale, Ill, and Robert Mason, MD, of Oxford, England.

◈ **Clair O Vingom, MD,** 83, Madison, died Feb 11, 1979 in Madison. Born May 26, 1895 in Mt Horeb, Doctor Vingom graduated from Washington University, St Louis, Mo. He practiced general surgery in Madison until his retirement in 1970. He was chief-of-staff of Madison General Hospital for seven years, served as president of the Dane County Medical Society, and from 1945 - 1949 he served as a Councilor to the State Medical Society of Wisconsin from the third district. He was chairman of the operating committee of Wisconsin Physicians Service from 1946 - 1949. Doctor Vingom was a member of the "50 Year Club" of the State Medical Society. Surviving are his widow, Esther, and one daughter, Mrs Kenneth (DeVolis) Tucker of Antioch, Ill.

Helen V Gruhl, MD, 62, former Milwaukee area physician died Feb 12, 1978 in Tucson, Ariz. Born Jan 16, 1917 in Baraboo, Doctor Gruhl graduated from the University of Wisconsin Medical School, Madison, in 1951. She had been on the medical staff of Milwaukee County General Hospital. Surviving are her husband; three sons, Frederick, Ann Arbor, Mich; James, Wayland, Mass; and Edward, Shorewood.

◈ **Forrest E Zantow, MD,** 60, Oconto, died Feb 12, 1979 in Oconto. Born Apr 12, 1918 in Madison, Doctor Zantow graduated from the University of Wisconsin Medical School, Madison in 1942, and served his internship at the University of Iowa Hospital. He served in the United States Army during World War II from 1943 until 1946. He was preceptor for the Physicians Assistant Program at the University of Wisconsin, Madison. Surviving are his widow, Florence; one daughter, Mrs James (Peggy) Bredeson, Beloit; and five sons, Peter, Manitowoc; Richard, Charlottesville, Va; William, Green Bay; Thomas and John, both of Madison.

◈ **Jasper M Molsberry, MD,** 82, Milwaukee, died Feb 12, 1979 in Milwaukee. Born Sept 18, 1896 in Plymouth, Iowa, Doctor Molsberry graduated from the University of Iowa Medical School in 1925. He had been a member of the medical staff at Milwaukee County General, Columbia, and Mount Sinai hospitals. He retired in 1973. Surviving are his widow, Marion Hazel; and a daughter, Mrs David (Shirley Ann) Elliott of Milwaukee.

Anthony V Cadden, MD, 75, Boca Raton, Fla, died Feb 13, 1979 in Boca Raton. Doctor Cadden, a pioneer in the treatment of tuberculosis, was the former head of the old Muirdale Sanitorium in Milwaukee. He retired in 1963. Surviving are two sons, Anthony V, Milwaukee, and John F of Clermont, Fla.

◈ **Donald D Peck, MD,** 57, Omro, died Feb 16, 1979 in Chicago. Born Oct 27, 1921 in Milwaukee, Doctor Peck graduated from the University of Wisconsin Medical School, Madison in 1946. He served in the United States Army from 1947 to 1949 and started his medical practice in Omro in 1950. Surviving are his widow, Elaine; two sons, Thomas, Phoenix, Ariz, and David, Omro; two daughters, Mrs Malcolm (Adele) West, Fullerton, Calif, and Diane Peck, Omro.

Oscar Gerhard Moland, MD, 69, Augusta, died Mar 21, 1979 in Augusta. Born July 8, 1909 in Hinsdale, Ill, Doctor Moland graduated from the University of Wisconsin Medical School in 1935 and served his internship at Norwegian Lutheran Deaconess Hospital, Chicago. He had practiced medicine in Augusta from 1936 until 1978, except for serving in the United States Army Medical Corps from 1940-1946 during World War II. Surviving are his widow, Pearl; one son, Gerhard, Long Beach, Calif; and two daughters, Sue Emmert, Jensen Beach, Fla, and Melody Kanten of Baldwin. ■

Toll-Free WATS line for members: 1-800-362-9080

As a service to its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference!

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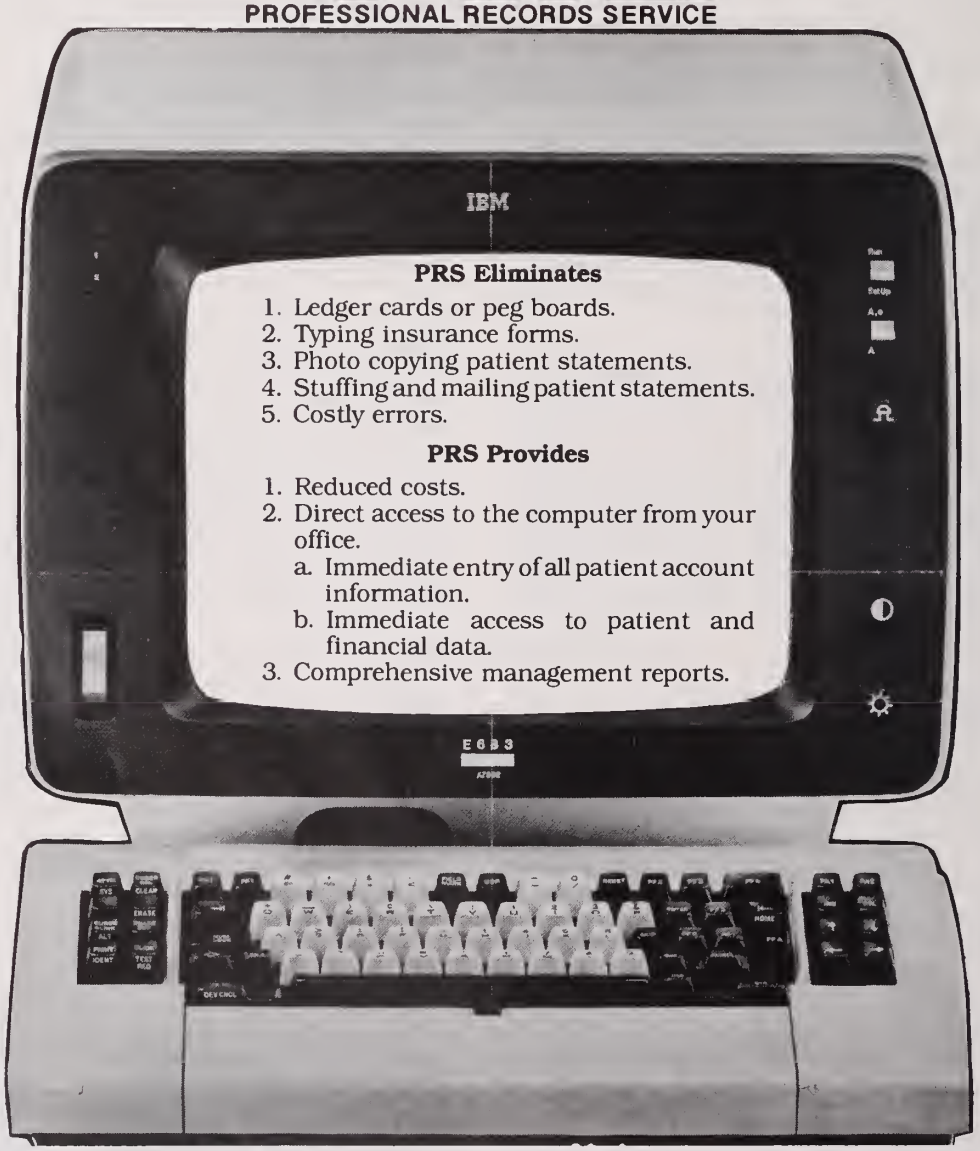

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

H Thomas Trieber, MD, Wautoma, has joined the medical staff of the Wautoma Memorial Community Hospital and the Wautoma Clinic. Doctor Trieber, who practices family medicine and obstetrics-gynecology, has been with the Veterans Administration Hospital in Tomah for the last eight years.

Jack D Spankus, MD,* recently became associated with the Ozaukee Medical Center, Thiensville, in the practice of orthopedic surgery. Doctor Spankus graduated from the University of Marquette Medical School and completed his orthopedic surgery residency at Wood, Columbia, and Milwaukee Children's hospitals. He is an assistant clinical professor at the Medical College of Wisconsin and is certified by the American Board of Orthopedic Surgeons. In 1976 Doctor Spankus was appointed as delegate to the Southeastern Regional Forum of the Governor's Congress for Handicapped Individuals.

Teresa E Quinn, MD, St Paul, Minn, will join the Quisling Clinic medical staff this summer and will be assigned as full-time physician for the new Waunakee Community Medical Clinic. Doctor Quinn graduated from the University of Wisconsin Medical School, Madison, in 1976, and is completing a three-year Family Practice Residency Program in St Paul.

H Peter Barnes, MD,* has joined the Wausau Medical Center in the practice of family medicine. A 1966 graduate of the University of Wisconsin Medical School, Madison, he had practiced for several years in Madison before moving to Wausau in 1976. He is on the medical staff of Wausau Hospitals.

Bruce Edmonson, MD, formerly of Seattle, Wash, recently joined the medical staff of the Richland Medical Center, Richland Center. Doctor Edmonson graduated from the University of Washington Medical School in 1970 and completed his residency training in pediatrics at the University of Wisconsin Hospitals, Madison.

James A Hinckley, MD,* Thomas G Kempken, MD,* Green Bay; and **John McDonough, MD*** of Wisconsin Rapids, recently were inducted as fellows of the American Academy of Orthopaedic Surgery at the Academy's 46th annual meeting held in San Francisco, Calif.

Michael K Mikkelson, MD,* Merrill, recently was awarded the "Distinguished Service Award" as the outstanding young man of the year from the Merrill Jaycees. Doctor Mikkelson has been a physician in Merrill since 1972. He serves as vice-president of the Lincoln County Health Resource Committee and the Lincoln County Medical Society; serves on the North Central Area Health Planning Association board and on the state physician service review board.

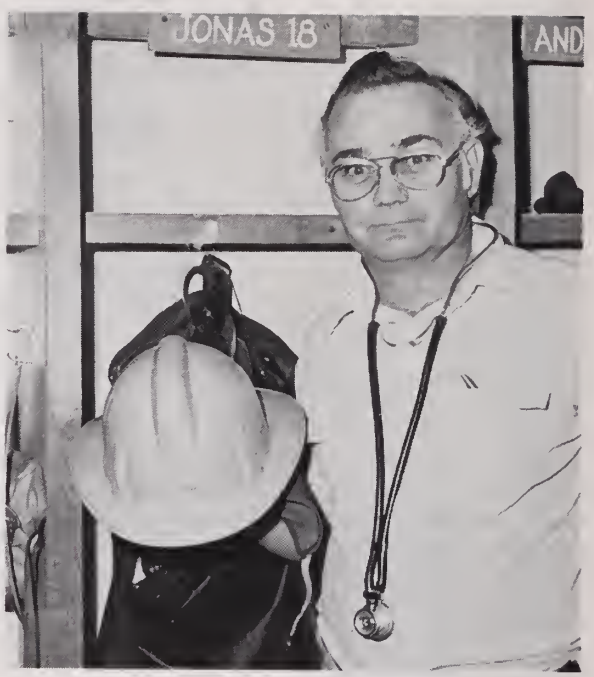
Young S Byun, MD, Manitowoc, recently joined the staff of Lakeshore Radiology Association. A graduate from the College of Medicine, Seoul National University in Korea, he served his internship at Mount St Mary's Hospital in Lewiston, New York, and his residency in radiology at University Hospital, Ann Arbor, Mich. Prior to joining the staff of Lakeshore Radiology Association, he was on the medical staff of University Hospital, Ann Arbor.

Kenneth Viste, MD* (left), program chairman of Winnebago County Medical Society, is shown with Rory Fisher, MD (center), and David Green (right), Evergreen Manor administrator. Doctor Fisher spoke to physicians and nursing home administrators at the monthly meeting of the Winnebago County Medical Society. A geriatric physician from Toronto, Canada, Doctor Fisher is currently working in the Department of Extended Care at Sunnybrook Medical Center, Toronto. (Photo courtesy *Oshkosh Daily Northwestern)*

Khamnung Thirakomen, MD,* recently opened his medical practice in Augusta. Board eligible in internal medicine, Doctor Thirakomen graduated from the Faculty of Medicine and Siriraj Hospital, Bangkok, Thailand, and served his residency at Mercy Hospital and Medical Center, Chicago. He also took a two-year fellowship in nephrology at the University of Illinois Medical Center in Chicago.

Leo R Weinshel, MD,* Whitefish Bay, has received the Outstanding Civilian Service medal for 30 years of distinguished service to the United States as senior physician at the Milwaukee Armed Forces Examining and Entrance Station. Doctor Weinshel began his service to the Milwaukee Armed Forces station in 1949.

Ted S Silver, MD, Boston, recently joined Burton A Waisbren Jr, MD,* Milwaukee, in the practice of cardiology. Doctor Silver graduated from Tulane Medical School, New Orleans, and completed an internship at Peter Bent Brigham Hospital. He received his invasive cardiology training at Massachusetts General Hospital.



Eugene R Jonas, MD* (above), Ellsworth, wears several hats, one of being a physician and the other of being a member of the village's volunteer fire department. As reported in the *Eau Claire Leader-Telegram,* the story around the fire department is that when the fire siren sounds in the village, Doctor Jonas hustles out the backdoor of his clinic to the fire station across the street where he becomes just another one of the firefighters. (Photo courtesy *Eau Claire Leader-Telegram)*

David J Ottensmeyer, MD, former chief-of-staff at St Joseph's Hospital, Marshfield, as well as chairman of the Department of Neurosciences, recently was the subject of a biographical article in an Albuquerque magazine. Doctor Ottensmeyer is now a hospital administrator in Albuquerque, NM. He is president of the Lovelace Medical Foundation and is medical director of the Lovelace Center for the Health Sciences.

John J Czajka, MD,* Hales Corners, recently was presented the annual "Service to Mankind Award" by the Sertoma Club of Milwaukee. Doctor Czajka, started the Guadalupe Medical and Dental Clinic to aid the Spanish-speaking community in health needs. The Clinic is medically staffed on a voluntary basis and there are approximately 20 medical doctors, 13 dentists, and about 50 other volunteers involved.

Brian Lloyd, MD, former medical director of the Northwestern Mental Health Center, Crookston, Minn, is joining staff psychiatrists MDs John Rohr and Larry S Garcia* at the Lakeland Counseling Center, Elkhorn, on a part-time basis. He completed his residency at Traverse City State Hospital, Michigan, and also served two years in the United States Navy in The Philippines.

CONTRIBUTIONS CES FOUNDATION MARCH 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1979.

Unrestricted

John V Flannery, MD; SMS Members—*Voluntary Contributions*

Restricted

Merck & Co, Inc—*Speakers Service*
American Family Insurance; Robert D Heinen, MD—*Medical Student Summer Externship Program*
Mrs William Janssen; Mrs Dean M Erickson; Mrs Carl W Munz; Mrs Harry H Danaher; Auxiliary to the Trempeleau-Jackson-Buffalo County Medical Society; Membership Dues—*Aesculapian Society*
RL Hansen, MD—*Museum of Medical Progress*

Memorials

Mary Angell—*Mrs Fredrick Stare*
George F Meisinger, MD—*Margaret Promen*
Eau Claire-Dunn-Pepin County Medical Society Auxiliary—*Oscar Moland, MD*
Ramona E Huebner—*Charles McGalloway*
State Medical Society—*Clair O Vingom, MD; Donald D Peck, MD; Jasper M Molsbury, MD*
Dr-Mrs Robert T Schmidt—*Guerin Dorschel; John A Sargent; Harold Smith (Brown County Loan Fund)*

Jagmeet S Soin, MBBS, Milwaukee, recently was admitted to fellowship in the American College of Cardiology.

John Allen, MD,* Wausau, recently became the new medical director of the Wausau Medical Center. A graduate of the University of Wisconsin Medical School, Doctor Allen has been in family practice in Madison, and has served as corporate medical director for Oscar Mayer and Company and as director of medical services for the Department of Health and Social Services.

John F Schwalbach, MD,* Sheboygan, recently was admitted to fellowship in the American College of Cardiology.

James C Tankersley, MD,* LaCrosse, recently received the 1979 Callon-Leonard Perinatal Award of the Wisconsin Association for Perinatal Care (WAPC). Doctor Tankersley, a pediatrician, is a member of the medical staff of Gundersen Clinic, Ltd. A graduate of Harvard Medical School, Boston, he has served as a co-director of the Western Wisconsin Regional Newborn Center and was a neonatal-perinatal coordinator of the Gundersen Medical Foundation's New Life Perinatal Project. The award is named for the pioneering perinatal care efforts of Wisconsin health professionals Helen F Callon, RN, and Thomas A Leonard, MD.*

Melvin F Huth, MD* (above) poses with the award given him by the Lions Club of Baraboo. As "Baraboo's Number 1 Basketball Fan" Doctor Huth has made it a point to witness every home game the T-birds play and even some out-of-town games. (Photo courtesy *Baraboo News-Republic)* ■

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News Highlights

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

American Academy of Pediatrics' February issue of its publication, *News and Comment,* listed Wisconsin physicians who had contributed to the Academy's "Speak Up for Children!" program during 1978. Five of them are SMS members: MDs Frederic M Blodgett,* Brookfield; Stephen Copps* and David H Corser,* LaCrosse; V J Cordes,* Wauwatosa; and L K Siegel,* Waukesha. In 1978 the AAP intensified its role of being an advocate for children by developing this special program in conjunction with the International Year of the Child—1979; and the 50th anniversary of the Academy in 1980. Various components of the Academy have participated in programs and plans throughout 1978 to prepare for the 1979-80 child advocacy events. More than 700 Fellows of the AAP made contributions totalling more than $20,000 in 1978 to support the "Speak Up" effort.

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The Faye McBeath Foundation of Milwaukee has awarded a $20,000 grant for the further development of the Hospice program and to facilitate the development of the home care program at Rogers Memorial Hospital in Oconomowoc. The Southeastern Wisconsin Health Systems Agency in September 1977 designated this program as a pilot program and one of two approved Hospice programs in the state. Robert Sewell, MD is the Hospice medical director.

Lutheran Hospital, Milwaukee, has announced the reelection of James S Ziolkowski, MD as chief-of-staff. Other positions filled are MDs David J LaFond,* vice-chief-of-staff; Conrad M Heinzelmann,* chairman, department of surgery; William L Deardorff, chairman, department of medicine; Frederick J Hofmeister,* chairman, department of obstetrics and gynecology; Roland C Brown,* secretary; and Richard H Lillie,* E Basil Jackson,* William C Rouman were elected members-at-large.

Marshfield Medical Foundation has announced the reelection of William F Schorr, MD,* president of the Foundation. Elected to serve with Doctor Schorr is Duane A Tewksbury, MD, secretary. Thomas F Nikolai, MD* was named to the executive committee. Doctor Schorr has been a member of the board of directors of the Foundation since 1966 and served as president in 1972 and 1973 as well as last year.

Beloit Memorial Hospital, recently elected Dionisio B Pili, MD,* president of the medical staff. A native of The Philippines, Doctor Pili began his medical practice in Clinton before joining Medical Associates of Beloit in 1973. He completed his internship and surgical residency at St Elizabeth Hospital, Chicago, and Oak Park Hospital, Oak Park, Ill.

The Milwaukee Gynecological Society recently installed Walter R Schwartz,* Wauwatosa, as president. The Society is composed of 130 Board certified and Board eligible obstetricians and gynecologists in Wisconsin. Other officers elected were MDs Jay A Larkey,* president-elect, and Stanley Korducki,* secretary-treasurer. Elected to the Board of Governors were MDs William Finlayson,* Eduard G Friedrich Jr, and Gerald L Mullaney.* ■

WPS

report

for Wisconsin Physicians

Volume VIII, Number 3

May, 1979

Health Care Financing Administration Is Reorganized

The physical relocation of the Health Care Financing Administration (HCFA) from Washington, D.C. to Baltimore which will be completed in June also ushers in a dramatic reorganization of the agency. On March 29, HCFA Administrator Leonard Schaeffer announced major changes in the agency's structure that facilitate the integration of Medicare and Medicaid program administration as well as the unification of HCFA's management control system.

The following are the most significant changes initiated by Schaeffer--changes which clearly highlight the HEW effort to arrive at ultimate integration of the Medicare and Medicaid programs.

--A new, single Bureau of Program Policy is mandated to consolidate policy activities now under the aegis of Medicare, Medicaid, and the Office of Reimbursement Practices.

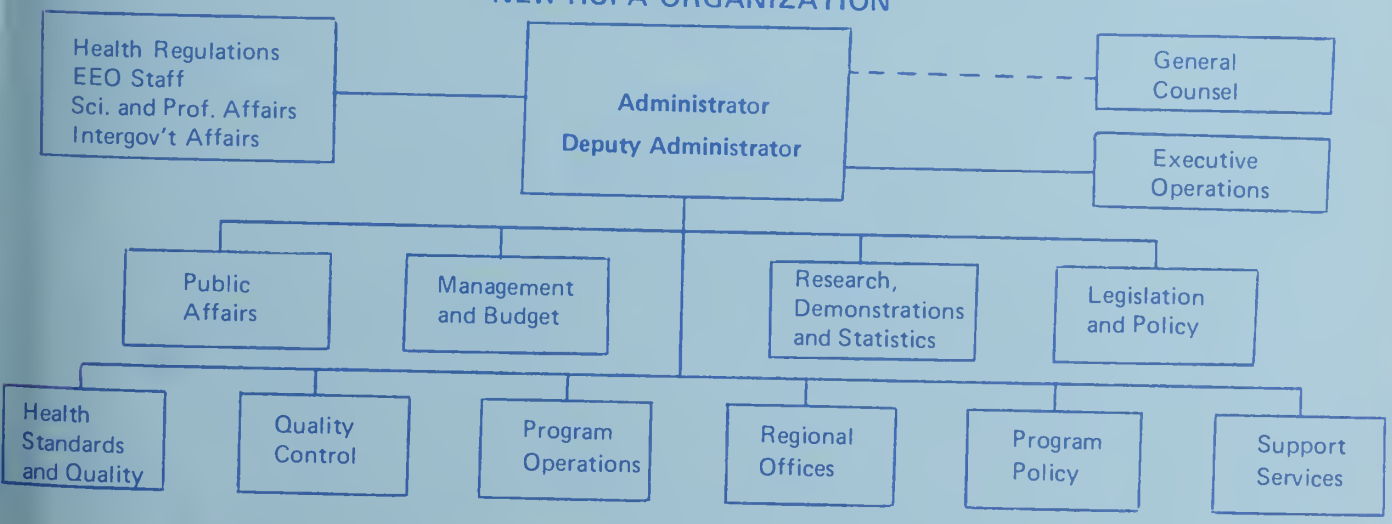
--A single Bureau of Program Operations consolidates contracting and state operations currently carried out in Medicare and Medicaid.

--A Bureau of Support Services consolidates centrally performed claims processing and other computer operations heretofore under the purview of Medicare and the Social Security Administration.

When the reorganization is completed in June, 2,600 of HCFA's employees are to be located in Baltimore, 195 in Washington, and the remaining 1,700 in regional offices. Although Schaeffer stressed that the basic HCFA mission of beneficiary services remains unchanged, HEW Secretary Califano stated that the reorganization represents "the farthest we can go under current law" to consolidate the administration of the Medicare and Medicaid programs.

The chart below reflects the HCFA organizational structure once the changes are completed in June.

NEW HCFA ORGANIZATION



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Since WPS is also the carrier for the Medicare Part B Program outside Milwaukee County, WPS provides a manual titled **Guidelines for Medicare Part B** for the use of the physician's office. This manual provides a brief history and description of Part B, explaining such items as the deductible and assignment or non-assignment of benefits. In addition, the manual gives a detailed, step-by-step set of instructions for completing the standard Medicare Part B claim form. In short, the booklet explains all the Part B procedural regulations which affect the filing of Medicare Part B claims.

Further information about each of these manuals may be obtained by writing:

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Attention: Elnora Johnson, CPCU
Telephone: (608) 221-4711,
Telephone: Extension 420

In addition to the written material which WPS has available, WPS also maintains a staff of field service representatives who are ready to answer any special questions or resolve any problems relating either to WPS regular policyholders or WPS Medicare Part B beneficiaries. The WPS Professional Relations Department may be contacted by telephoning (608) 221-4711, Extension 374.

WPS intends to continue to work closely with physicians and their office assistants throughout the state to achieve the most efficient claims processing procedures possible. The services which have been described are a part of this effort.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

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FAMILY PHYSICIAN — O/B experience. Emergency Room Physician—July, August 1979. Opportunity for one of each in northern Wisconsin resort town of Eagle River. New clinic facility attached to hospital. Drawing area includes all of Vilas County, parts of Oneida, Forest, plus a large tourist and retirement population. If interested, contact: Charles E Reevs, Admin, Eagle River Memorial Hospital, Eagle River, Wis 54521. Tel: 715/479-7411. 1tfn/79

IMMEDIATE VACANCY FOR staff physician at Wisconsin Veterans Home, King, Wisconsin 54946. Institutional geriatric practice of 700 patients. Located in an excellent summer and winter recreational area, the Wisconsin Veterans Home offers a challenging medical opportunity with the added benefits associated with small community living. We offer a competitive salary, liberal fringe benefit program, regular hours, paid malpractice insurance and other benefits. Please contact: John Peters, Personnel Manager. "An equal opportunity employer, operating under an affirmative action program." 5-6/79

EMERGENCY SERVICE PHYSIcians needed for a 24-hour emergency service in a fully accredited acute-care facility located in a beautiful northeastern Wisconsin community. Your off-duty time can be filled with year-round recreational activities. Excellent salary, malpractice insurance paid. Other attractive fringe benefits. Interested physicians write to: C Vincent Cassiani, Executive Vice-president, Clintonville Community Hospital, 35 North Anne St, Clintonville, Wis 54929; or call collect 715/823-3121. 5/79

WANTED: TWO FAMILY PHYsicians preferably ABFP for association with the Family Medical Center, Sheboygan, Wisconsin. Please call or write: Martin A Rammer, MD, 1930 N 8th St, Sheboygan, Wis 53081; phone 414-457-5016. 5tfn/78

OB-GYN: IMMEDIATE OPENing with 9-man, multispecialty group. To join present Ob-Gyn, four internists, two pediatricians, and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing—pension plan. Young group. Contact James L Algiers, MD or Clinic Manager, Parkview Medical Associates, Ltd, 1004 East Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/79

FAMILY PHYSICIAN: WAUSAU to join three board certified ABFP physicians. New medical office opened March 1978 and new hospital to open in 1979. Contact: R E Cadwell, MD, 212 Sturgeon Eddy Rd, Wausau, Wis 54401. Tel: 715-842-0491. 10tfn/78

PHYSICIANS—WE SAVE YOU TIME AND KEEP YOUR CAREER LOCATION SEARCH COMPLETELY CONFIDENTIAL

We're all medical professionals ourselves so we recognize outstanding opportunities. Tell us your geographic and position choices and salary expectations. We'll match them with the career opportunities we have available in Wisconsin as well as nationwide.

Contact Donna Herschleb, RN

HORNER MEDICAL PLACEMENTS

802 W Broadway, Suite L-6M
Madison, WI 53713
Tel: 608/222-1616

Licensed Employment Agency

1tfn/79

Physicians Exchange

continued

WANTED: FAMILY PRACTICE physician to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

FAMILY OR GENERAL PRACtitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

DANE COUNTY WILL BE requesting proposals to provide medical and psychiatric services at its Hospital and Home, Verona, Wisconsin. The time commitment for medical services would be approximately 72 hours per month. Psychiatric services would require approximately 85 hours per month. If interested and want to obtain information or be placed on the mailing list, please write or call Mr Kevin F Gould Jr, Purchasing Agent, Dane County Purchasing Division, Room 100, 210 Monona Ave, Madison, Wisconsin 53709. 608/266-4184. 5/79

MANITOWOC CLINIC, SC IS seeking OB-GYN and pediatric specialists to join an established successful practice with 16-man multispecialty group. Excellent group benefits; retirement plan; modern clinic facilities; community has excellent educational system including two colleges; area population 80,000; outstanding recreational facilities; must be Board certified or eligible. Contact: Administrator, Manitowoc Clinic, SC, 601 Reed Ave, Manitowoc, Wis 54220. 5-12/79,1/80

GENERAL INTERNIST WITH GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info: J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

BOARD CERTIFIED DIAGNOStic radiologist available to provide consultation service: 1) to physicians in an office setting or at small community hospitals in Wisconsin: 2) for other radiologists in small solo practices who desire "Locum Tenens" coverage for CME purposes for up to one week. Contact Dept 465 in care of the Journal. 4-5/79

FAMILY PRACTITIONERS OR internist and pediatrician for satellite primary care office located in West Allis, Wis. Call shared by other members of 34-physician multispecialty group. For further information contact E Daun, Administrator, Northpoint Medical Group, 2388 N Lake Dr, Milwaukee, Wis 53211. Tel: 414/289-3918. 4tfn/79

WANTED MEDICAL SPECIALties — small town between Milwaukee and Chicago serving a shopping area population of 50,000. Has 140-bed hospital, 14 GPs, 3 OB/GYNs, 1 ophthalmologist and 1 orthopedic surgeon. Custom built office space in superbly located new building. For full details contact Arthur L McCourt, 148 S Pine St, Burlington, Wis 53105. Tel: 414/763-7697. 4-9/79

WANTED: ORTHOPEDIST INterested in part-time work (15-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wis 53705. If interested, please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel. 608/266-1989. 2-5/79

WISCONSIN-LOCUM TENENS emergency medicine in Eagle River, Wis. June-August; weekends only; excellent specialty backup; Lake housing available; $1100/weekend plus paid liability insurance. Contact Tom Cooper, MD, 1-800-325-3982. 5-6/79

Medical Facilities

MEDICAL CLINIC SPACE available. Janesville Road and Pioneer Drive, Muskego. 2,500 sq ft on ground floor. Modern, move-in condition. Please contact: Roger Bothe, John Herschede & Associates, Inc. Tel: 414/933-0585. 7tfn/78

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOND DU LAC FACILITY. Complete medical practice suite available soon. Suitable for group practice of five or six, or a pair and three. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

FOR SALE: PHYSICIAN AND surgeon deceased. Lovely lannon stone home and two doctor offices with x-ray, consultation drug room, large waiting room and business office, and private offices in A condition with two-car garage. Call 414/863-2106. g2tfn/79

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

OFFICE SPACE AVAILABLE IN highly populated area south of Madison Coliseum on Rimrock Road. This is a new shopping center. Contact George Icke, phone 271-5414. p5/79

1875 SQUARE FEET MEDICAL and/or dental office space available near downtown Sheboygan, Wis, in physician-occupied building. Contact Dept 466 in care of the Journal. 5-7/79

WANTED: USED X-RAY EQUIPment, accessories, ultrasonic and diathermy equipment. Call 414/444-7125. 5tfn/79

Announcements

The National Hemophilia Foundation is now accepting applications for its 1980 Judith Graham Pool Research Fellowships. Awards are granted for studies in clinical and/or basic science which are aimed at furthering understanding, or improving management, of the hemophilias and von Willebrand's Disease. Proposed research may concern biochemical, genetic, or may focus on rehabilitation, therapeutic modalities, or social features of the hemophilias. Information and application forms are available from The National Hemophilia Foundation, 25 West 39th St, New York, NY 10018. Deadline for application is October 1, 1979. Awards will be announced by December 31, 1979.

Research opportunities offered by Leukemia Society of America. The Leukemia Society of America, Inc is now accepting applications for grants to support research in the fields of leukemia and related disorders. Grants are intended to encourage studies at both the basic science and clinical levels. Five-year scholarships for a total of $100,000 are available for researchers who have demonstrated their ability to conduct original investigations in the specified fields. Two-year special fellowships and fellowships for $31,000 and $25,000, respectively, are offered for those in the intermediate and entry stages of career development. Deadline for filing applications is Sept 1, 1979. Reviews of applications will take place next January with funding to start July 1, 1980. Application forms and further information may be obtained by writing Dr Kenneth McCredie, Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc, 211 East 43 St, New York, NY 10017.

Films/Audiovisual

Surgical-technique film dealing with the correction of a herniated lumbar disc now available from the American College of Surgeons Surgical Film Library. A Milwaukee surgeon, Dr Glenn A Meyer, is the author and is featured in the film. Doctor Meyer is associate professor at the Medical College of Wisconsin, Milwaukee, and a Fellow of the ACS. The film was first shown at the 1978 Clinical Congress of the ACS in San Francisco in October. It was one of 15 motion pictures prepared this year by recognized specialists in their fields, at the request of the ACS. Each such film usually is a composite of several operations, some of many hours duration. As edited for screening, they run from 15 to 28 minutes. Fifteen to 20 films in various fields of surgery are produced each year for the Cine Clinic, a joint educational endeavor of the ACS and Davis & Geck. Davis & Geck, the Danbury, Connecticut manufacturer of surgical sutures, is a department of Lederle Laboratories Division, American Cyanamid Company. announcements

Publications

Feeding Infants. A nutrition monograph for health professionals. As a result of numerous requests about and interest in the area of infant feeding, the public health nutrition staff of the Wisconsin Division of Health devoted all of the 1977 "Nutrition Newsletter for Nurses in Community Health Services" to current recommended practices in infant nutrition. This monograph is a compilation of the newsletters. Some of the topics presented are controversial and subject to individual interpretation. Nutrition research is dynamic, thus, there is not always one correct answer. The information which follows is current and supported by reliable references. It is hoped this monograph will be of assistance in your education and counseling efforts. The preparation of the newsletters and this ensuing monograph represent the combined effort and expertise of the public health nutrition staff with editing and review by the Maternal and Child Health Section of the Wisconsin Division of Health. Major contributions in reviewing research and clinical practice as well as in drafting the manuscript have been made by Wisconsin Division of Health Public Health Nutritionists: Scherle Barth, RD, MS; Betty Griffin, RD, MPH; Laurie Norstedt, RD, MS; Linda Peterson, RD, MPH; Mary Jo Tuckwell, RD, MPH; Terry Williams, RD, MPH; and Elizabeth Spencer, RD, MS (North Central Perinatal Center). The monograph has been reviewed and endorsed by the Wisconsin Chapter of the American Academy of Pediatrics. The 54-page, 8 1/2 x 11 inch publication is available free (in single or small quantity) upon request to: Bureau of Community Health Services, State Division of Health, PO Box 309, Madison, Wis 53701; or phone 608/266-2661.

Occupational Health Guide for Medical and Nursing Personnel. Updated, expanded. First published by the State Medical Society of Wisconsin in the 1960s. Respected throughout the United States as well as in Wisconsin by nurses and physicians in the commercial and industrial setting. This latest edition is the result of substantial change. This practical manual in a three-ring binder covers subjects ranging from "Abdominal Injuries" to "Wounds." Spaces are provided for specific written instructions by the occupational physician. It contains over 100 pages of instructional material, suggested procedures, and references to other occupational health literature. Order the ring book complete, or order only the inserts if your organization has its own ring binder.

Complete guide with ring binder $11.00*
Extra copies, without ring binder $10.00*
*plus 4% sales tax
postage is included

Checks payable to: CES Foundation, State Medical Society of Wisconsin. Order from: Committee on Occupational Health, SMS of Wisconsin, Box 1109, Madison, Wis 53701. ■

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1979 Others

continued

Aug 2-5: International Doctors in Alcoholics Anonymous Annual Meeting. Holiday Inn at the Embarcadero, 1355 North Harbor Dr, San Diego, CA 92101 (specify IDAA Meeting), or call 800/453-5555. For further information, contact Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511. Tel: 216/782-6216.

ASPEN MUSHROOM CONFERENCE. Identification of edible, poisonous and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and advanced courses. AMA Category 1. July 29-Aug 3, 1979. Wildwood Inn, Snowmass-at-Aspen, CO. Contact: Beth Israel Hospital, 1601 Lowell Blvd, Denver, CO 80204. Tel: 303/825-2190, ext 550. 5-6/79

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1979-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1979 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

Aug 13-15: Aspen Seminar—**Medical Staff law and bylaws.** Be prepared for the new JCAH guidelines. At The Abbey on Lake Geneva, Fontana, Wis (ph 414/275-6811). Two and one-half days. Tuition: $335. Register with Registrar, Aspen Systems Corporation, 20010 Century Blvd, Germantown, Md 20767; or call 301/428-0700.

Aug 27-31: American Institute of Ultrasound in Medicine (AIUM) will conduct its 24th Annual Meeting in conjunction with the 8th Annual Meeting of the American Society of Ultrasound Technical Specialists, in Montreal, Canada. Scientific sessions, scientific exhibits, poster sessions, and one of the largest ultrasound instrumentation exhibits in the United States. Info: AIUM/ASUTS Montreal '79, 6161 North May Ave, Suite 278, Oklahoma City, Okla 73112 (405/840-3721).

NATIONAL MEDICAL SPECIALTY SOCIETIES

1979 Meeting Dates/Sites

Jul 7-14: American Society of Clinical Pathologists, Washington, DC. Info: J L Normoyle, 2100 W Harrison St, Chicago, IL 60612.

Sept 16-20: American College of Radiology, Chicago, Ill.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

Oct 8-11: American Academy of Family Physicians, Hilton Hotel, Atlanta. Info: R Rusken, 1740 W 92nd St, Kansas City, MO 64114.

Oct 13-18: American Academy of Pediatrics, St. Francis Hotel, San Francisco. Info: R G Frazier, MD, 1801 Hinman Ave, Evanston, IL 60204.

Oct. 22-26: American College of Surgeons (Clinical Congress), Chicago. Info: E Gerrish, MD, 55 E Erie St, Chicago, IL 60611.

Nov 3-4: American Association of Ophthalmology, San Francisco. Info: L A Zupan, 1100 17th St NW, Washington, DC 20036.

1980 Meeting Dates/Sites

Mar 9-13: American College of Cardiology, Houston, TX.

Sept 10-11: First National Conference on Antibiotic Review: West Coast Update, Bonaventure Hotel, Los Angeles, CA. Info: Muriel Myers, 67 Peachtree Park Dr, Suite 118, Atlanta, GA 30309.

Sept 15-16: Workshop on Practice Management, presented by AAFP Commission on Health Care Services' Subcommittee on Practice Management in conjunction with the Iowa Chapter. Program carries 11 1/2 hours of Prescribed AAFP continuing education credits. Registration fee for physicians, office managers, and aides is $100. Further info: Chet Watts, AAFP Dept of Registration and Housing, 1740 West 92nd St, Kansas City, MO 64114, or call him at 1-800-821-2512.

Oct 8-11: American Academy of Family Physicians Scientific Assembly, Atlanta, Ga.

Nov 1-4: National Perinatal Association Meeting, St Louis, Mo. Contact: Convention Director, National Perinatal Association, 200 East Chestnut St, Louisville, Ky 40202. g9/78

1979 AMA

July 22-26: Annual Meeting, Chicago, IL. Contact: James H Sammons, MD, Exec Vice President, 535 N Dearborn, Chicago, IL 60610. g2-6/79

Oct. 12-13: *Medical Staff Leadership Seminar (Advanced)*, Resorts International Hotel, Atlantic City, New Jersey. Program outline: 1) Refinements of medical staff organization. 2) Health planning and other external constraints. 3) Alternate methods of quality assurance. 4) Maximizing leadership positions: management and leader techniques. Registration fee: $200 for AMA members, $300 for nonmembers. CME credit: 14 hours in Category 1 for PRA-AMA. Further info: Call (312) 751-6657 or write to the AMA Dept of Hospitals & Health Facilities, 535 North Dearborn St, Chicago, Ill 60610.

Nov 9-10: *Patient Safety/Risk Control Seminar.* The Breakers, Palm Beach, Florida. Course outline: 1) Recent developments in malpractice legislation and litigation; impact on medical care. 2) Professional liability insurance. 3) Physician participation in quality assurance and patient safety programs. 4) Responsibilities of the medical staff, governing board, and administration. 5) Delineation of privileges for physicians and nonphysician professionals. 6) The medical

staff's potential liability for others. 7) A plaintiff's attorney looks at medical risks. 8) A defense attorney looks at medical risks. 9) The importance of medical staff influence in public and patient relations. 10) Patient complaints: frustration or medical error?. Registration fee: $200 for AMA members, $300 for nonmembers. CME credit: 14 hours in Category 1 for PRA-AMA. Further info: AMA Dept of Hospitals & Health Facilities, 535 North Dearborn St, Chicago, Ill 60610; or call (312) 751-6657. ■

Twenty Second Meeting of the WISCONSIN NEUROLOGICAL SOCIETY

Friday-Saturday, June 1-2, 1979—Heidel House, Green Lake

Meetings of the Wisconsin Neurological Society are open to all interested physicians and all allied health personnel. This meeting is approved for Category 1 credit. The Wisconsin Neurological Society is accredited for Continuing Medical Education.

Friday, June 1 (8:00-10:00 pm)—Dr R Clarke Danforth will preside over the usual, informal and educational program aimed at the elucidation of various clinical and laboratory problems.

Saturday, June 2 (9:00-10:20 am)—MUSCLE DISORDERS

Multicore Core Disease: A R Sulaiman, MBBS, James W Albers, MD and Kenneth Siegesmund, PhD, Milwaukee

Penicillamine Induced Myasthenia Gravis: R J Hodach, MD, J W Albers, MD and W Treacy, MD, Milwaukee

Deterioration of Penicillamine Induced Myasthenia Gravis with Pancuronium: Robert Graebner, MD, J W Albers, MD, Robert Gilbert, MD, Madison

Superior Oblique Myokymia: D Frens, MD, Marshfield

Saturday, June 2 (10:40-11:45 am)—EPILEPSY

The Role of CT Scanning in Epilepsy: Francis M Forster, MD and Charles M Strother, MD, Madison

"Spindle Coma"—an EEG Pattern of Uncertain Value?: P Hansotia, MD, P Gottschalk, MD, P Green, MD, Marshfield

Paroxysmal Action of Inhibitory Amino Acids on a Model of Cortical Reticular Epilepsy: James Black, MD, Greg Golden, PhD, and R G Fariello, MD, Madison

Saturday, June 2 (11:45 am—12:45 pm)—LUNCH

Saturday, June 2 (1:00-2:00 pm)—GUEST SPEAKER

The Past, Present, and Future of Brain Imaging: William Oldendorf, MD, Professor of Neurology and Psychiatry, UCLA School of Medicine and Senior Medical Investigator, VA Brentwood Medical Center

Saturday, June 2 (2:00-4:00 pm)

Diagnostic Studies in Communicating Hydrocephalus: Bupendara Khatri, MD, Winslow Borkowski, MD and William Willems, MD, Milwaukee

Arnold Chiari: Type III Malformation Without Hydrocephalus: D Frens, MD, Marshfield

Percutaneous Trigeminal Thermal Rhizotomy for Trigeminal Neuralgia: David E Ostrow, MD, Milwaukee

Brucella Meningoencephalitis in Childhood: H M Swick, MD, Milwaukee

Cough Headaches: R Clarke Danforth, MD, Victor Haughton, MD, Michael McQuillen, MD, Glenn Meyer, MD and Bupendara Khatri, MD, Milwaukee

Tourett's Syndrome: S Zinsmeister, MD, L Ptacek, MD, D Frens, MD, Marshfield

Saturday, June 2 (4:00 pm)—BUSINESS MEETING

Dr R Clarke Danforth, President: The Wisconsin Neurological Society meets semiannually, in late October and in May or June. The scientific meetings are open to all interested physicians. Members and guests are required to register so their attendance can be verified for accreditation for CME.

Officers: President—C Clarke Danforth, MD, Milwaukee
President-elect—Raymond W M Chun, MD, Madison
Vice-president—Phiroze L Hansotia, MD, Marshfield
Secretary-Treasurer—Michael P McQuillen, MD, Milwaukee
Secretary for Continuing Medical Education—Francis M Forster, MD, Madison

18th ANNUAL MEDICAL-LEGAL-INDUSTRIAL SYMPOSIUM

Friday, November 9, 1979

Hotel Pfister/7th Floor
Milwaukee, Wisconsin

Cancer and Industry

Program

am

8:00 Registration

9:00 Welcome / Daniel A Kane, Executive Vice-President, Mount Sinai Medical Center

9:05 Introduction/Sidney K Wynn, MD, Symposium Chairman, Mount Sinai Medical Center

9:10 The Politics of Cancer/ Samuel S Epstein, MD, Professor of Occupation and Environmental Medicine, School of Public Health, University of Illinois

10:35 Cancer of the Lung as Related to Industry/ Norbert Enzer, MD

11:05 Surveillance Studies in Industry/Sidney Shindell, MD,LLB, Professor and Chairman Department of Preventive Medicine, MCOW

11:30 Metals Intoxication as Related to Cancer/Carl Zenz, MD, School of Occupational Medicine

pm

1:30 Role of RN in Early Detection of Cancer/ Judy Hayes Bernhardt, Associate Professor of Occupational Health Nursing, School of Nursing, University of Wisconsin-Milwaukee

1:50 Compensability of Occupational Cancer/Attorneys Leonard S Zubrensky and John H Jones; and Hugh Russell, Workers Compensation Division

2:50 Question and Answer Period

Further information contact Mount Sinai Medical Center, Medical Center Relations, PO Box 342, Milwaukee, Wisconsin 53201.

News You Can Use

Health planning conference rescheduled. The State Medical Society Conference on Health Planning originally slated for June 8 and 9, 1979, has been rescheduled for early October. Joining SMS in cosponsoring the conference will be the Wisconsin Hospital Association. Because of significant interest expressed by physicians and hospital administrators involved in the planning process, it was agreed by both SMS and WHA that an October date would allow for the greatest possible participation in the conference. The conference will scrutinize the health planning mandates and analyze whether health planning objectives are being met in controlling healthcare costs, assuring the quality of care, providing accessible healthcare services, and preventing duplication of health services. Special attention will be focused on whether health planning has been effective in controlling costs in Wisconsin. Hospital rate review, certificate of need, decertification, and other cost-containment initiatives will be examined. More information will follow in future issues of WMJ.

Midwest health planning workshop slated. A reminder. . . the American Medical Association is sponsoring a "Midwest Regional Health Planning Workshop" in Chicago on June 15 and 16 at the Hyatt Regency, O'Hare. Planned with the assistance of the Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin medical societies, the conference will include workshops on: "National Guidelines and Local Health Planning;" "Rural Health Planning: The Positive Potential;" "The Regulatory Aspect of Health Planning;" "HSP Implementation: Total Public Involvement;" "SHCC/SHPDA/HSA: Striking a Balance;" "Data and Methodology — The Acute Care Component;" and "The Physician and Consumer as Joint Participants in Decision-Making." For further information contact the SMS Health Services Division in Madison.

AMA regional CME program scheduled. The AMA's Regional Continuing Medical Education Program will be held this year on Saturday and Sunday, July 21-22, at the Sheraton Ritz Hotel, Minneapolis. Physicians attending the program can earn up to 12 hours of Category 1 credit for the AMA's Physician Recognition Award for 1980-81 Wisconsin relicensure requirements. Program topics include: "Basic Electrocardiography;" "Cardiac Arrhythmias;" "Office Gynecology;" "Chest Roentgenograms;" "Emergency Management of Life Threatening Injuries," and "Important Recent Advances in Drug Therapy." Physicians will also be interested in two programs carrying Category 2 credit on "Communications for the Medical Speaker" and "Enhancing Your Financial Skills."

Study shows rising concern about health matters. Despite high interest and concern about personal well-being, few Americans regularly practice good health habits, a new national survey shows. Major obstacles to wholesome lifestyles cited in the survey done for General Mills, Inc includes: inflationary pressures which are forcing one out of two families to cut back on some essential preventive care practice; lack of commitment to follow preventive health measures such as exercise and weight control; and confusion about what constitutes a good health practice. The survey also revealed the following reasons as to why families are not following through on today's new health care: for six out of ten family members, seeing a psychiatrist or psychologist is a last resort; to cope with inflation and rising medical costs, 48% of American families are cutting back on the quality of daily diets, visits to doctors and dentists, the purchasing of new eyeglasses and other health practices; despite all the information on health information being distributed, only one in four families feels well-informed about good health practices.■

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WISCONSIN MEDICAL JOURNAL

JUNE 1979

• Annual "Blue Book" issue: Presented each year since 1924 as a reference source on medicolegal, socio-economic, legislative, governmental matters of direct concern to the physician. Also a reference source on State Medical Society organizational structure, other related organizations, and state government agencies

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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State Medical Society of Wisconsin

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Representing 4,700 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* the official publication of the Society.

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record in drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
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Editorials

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Regional Medical Journals — a regurgitation

THE COW IS A REMARKABLE ruminant. Some subjects, like the bovine cud, tend to surface at intervals. This time it's the suggestion that the *Wisconsin Medical Journal* band together with several publications in neighboring states to produce a regional medical journal.

Whenever a commission or committee is infused with new members, innovations are suggested. That is, the innovations are original with the new members, but often have proved to be stale news to those who have been around a bit longer.

The possibility of the regionalization of this Journal has been considered for at least the past two decades. In one instance a neighboring state journal was seeking bed partners. Investigation showed that the journal in question was an extremely inefficient production with a large paid staff looking for friendly neighbors to help bail it out. (In contrast the Wisconsin journal has a full-time paid staff of only two.) Another time a journal wanted to amalgamate in a midwest or Great Lakes regional journal. The editor of the other journal did indeed put out a very slick publication. The cover resembled Joseph's coat of many colors and was always a thing of beauty. Agreed that our own Journal cover with its traditional half-page ad will not win any artistic awards, but it does bring in about $3,000 each year. Anyway, the other editor almost bankrupted his state medical society and we elected not to join him.

There have been regional medical journals in the past. For example, there was one in the northwest that was published jointly by several states. This is no longer in existence and the same is true of what was once called the *Mississippi Valley Medical Journal.*

If a regional journal materialized, much of the advantage and function of individual state journals would be lost. Too much of the material is of interest only to the physicians within a single state and there are more than enough scientific articles to go around.

So, like the contented cow, we will once again ruminate on the subject of the regional state journal.—VSF

Mind-boggling figures

A NEW YORK JURY ORDERED a plastic surgeon to pay a 42-year-old woman $854,000 for her misplaced umbilicus. Her photograph indicated that she was certainly no American beauty, but she was having a hearty belly laugh following the stupendous award.

This has been widely publicized as the case of the misplaced bellybutton and has established a staggering precedent. It is not possible to estimate how many people would be privileged to contemplate her navel, nor how many might have viewed her sagging abdomen prior to the shift lateral or to the midline.

The sad thing about this is the misplaced set of values. If an individual in industry loses an extremity, or becomes totally disabled, the compensable value is relatively modest compared with the astronomical award for this minor asymmetrical nonsense.

Then there is Dr Peter Bourne, of Bourne-again fame, as Columnist Nick Thimmesch calls him. He has surfaced again, after a brief fall from power. Doctor Bourne now has a new position with the United Nations, thanks to the good office of the White House and State Department, to help plan a major water development conservation program. His income is reported to be between $40,000 and $50,000 a year. With his background in psychiatry and drug abuse, he should be invaluable in the international waterworks. His wife is paid $50,000 a year as deputy director of ACTION. ACTION is the agency that controls Vista and the Peace Corps. It must be gratifying to the volunteers in these two programs who are working for peanuts all over the world to know that Mrs Bourne is so generously rewarded for shuffling papers back in Washington.—VSF

Malpractice

NEWS ITEM:

A New York woman has been granted an award in excess of $800,000 to assuage pain, suffering, anguish, and embarrassment due to an

off-center navel resulting from abdominal plastic surgery.

Her surgeon is reported to have said:

"Though my tucks really made her quite svelte,
My poor bankroll has started to melt.
She's decided to sue—
with her navel askew,
She can't find where to buckle her belt!"

—WJB

Wasps

WITH THE PASSAGE of the years does one tend to become more mellow or more waspish? By waspish I refer to the stinging hymenopterous version and not the color, ethnic and religious connotation. Perhaps it's my own need for antihypertensives that has made me aware that more things are bothering me all the time. For example: It has been proposed that the registration of young people take place in the event that a draft should be necessary for the military in the future. Before this proposal got off the ground there were loud protests. This included not only the young people who might be required to register but also the usual claque of ranting gray beard professional protesters. Some of these are reminiscent of the "gray beard loon" in the Rhyme of the Ancient Mariner.

Older physicians are naturally reminded of their own military service. In World War II this extended anywhere from four to six years and many of the young physicians of that time called themselves "The Lost Medical Generation." Quite the contrary proved to be true as a tremendous program of residencies, paying handsome monthly stipends of $50, opened up after World War II, and a generally outstanding group of well-trained, mature physicians emerged. Not long after World War II there was a "special doctor draft" registration, but it didn't touch off any demonstrations.

Totally unrelated but a cause for consternation was a bit of news from the University of Wisconsin. This reported that half a dozen members of the UW "athletic community," including some prominent football and basketball players, had taken part in campus drug thefts during the school year. These jocks had stolen high-grade Hawaiian marijuana called "Maui Wowie" from a small-time dealer in a University dormitory. The District Attorney was in a quandry because the alleged victim or drug dealer decided he didn't want to testify against the athletes. The dealer, of course, was interested in protecting himself both physically and legally. During the theft one of the football players allegedly held a "knife-like medical tool" to the dealer's throat. The so-called victim of the theft freely admitted he had been selling in the dormitory up to $500 worth of marijuana weekly for several weeks prior to the thefts. But there is no prosecution in store for him either.

An ironical and sad commentary on the sordid situation was that this all took place in Bradley Hall. This dormitory was named for Dr Harold Bradley, one of the finest gentlemen ever to come to the University of Wisconsin campus and one of the early and sturdy pillars in its medical school.

I know every older generation always is sure that the younger generation is "going to hell in a handbasket." Whether that is its destination, life is certainly not static.—VSF

Gunnar Gundersen, MD: 1897-1979

Medicine has lost one of its giants . . . not only as an organizational leader but also as a conscience, as an inspiration, as an example of the best in physician care and concern for human welfare. His death on May 22, 1979 brought personal sadness to me because Gunnar gave me such great help and guidance in those early years of my affiliation with the Society. His commitment made mine stronger. His enthusiasm kindled mine. And how greatly I enjoyed the miles and hours we traveled together up and down the highways of Wisconsin. He was a treasure of history, geography, and folklore of Wisconsin. Bless him.—ERT ■

THE COUPON AGENCY?

Dear Accounts Receivable Manager

If you ever have had the chance to help your doctor produce the most dollars for his practice, you have it now.

Some doctors have switched to the coupon type agency. Your evaluation can produce a large number of lost dollars.

If you are using a coupon agency, please consider the following comments.

1. *The doctor is paying for three letters, whether the account is paid or not. Even when the first letter is returned the doctor pays. What skip tracing is being done on the accounts?*
2. *Are you sitting with a half used coupon book and a large number of uncollected accounts even though many of the accounts have completed the three letter series? What now?*
3. *Are the large balances referred immediately to an attorney in cases where patients refused to pay or is the letter series just continued?*
4. *The law states that once the patient involves an attorney all correspondence with the patient must stop. Does the letter sequence continue and leave you open for possible problems?*
5. *Is the total collection by the coupons doing the job you thought it would?*

If your doctor is in any of the above positions, please have them consider us. We will supply you with a ten-day collection letter free of charge, have the account in the hands of a professional phone collector to contact immediately, resolve any disagreements or misunderstandings between doctor and patient, and have one of the following results in 45 days: Payment in full, a satisfactory payment plan, decide if legal action is necessary, or a disposition of the account.

Sincerely,

John H. Wild

John H. Wild
Collection Manager's Service
231 West Wisconsin Avenue
Milwaukee, WI 53203
Phone: 1-414-272-1673

Letters

How you going to keep them down on the farm?

EDITOR'S NOTE: Completely by coincidence, and without collusion, consultation or connivance, both VSF and WJB submitted editorials in April with identical titles ("How you going to keep them down on the farm?"). These were for the May issue of WMJ. However, the Council at the Annual Meeting in Milwaukee, adopted a position opposite that expressed in the editorials. Although approved by the Editorial Board, they are now being published as opinions by the authors and obviously do not reflect the views of the Council, the governing body of the State Medical Society. Additional views are welcome.

* * *

In an attempt to assure settlement of physicians in allegedly underserved areas of Wisconsin, Representatives Czerwinski and Offner have developed a draft proposal for Wisconsin Health Education Assistance Loan and Forgiveness Program. The proposal is not yet in the form of a bill, but before this report goes to press, the proposal will have been put before the Joint Finance Committee for inclusion in the budget. The budget bill is scheduled for action in late June, and the proposal, if approved, would become effective in the fall of 1980.

In essence, as the draft proposal is now written, the state would offer guaranteed loans to medical students attending the University of Wisconsin and the Medical College of Wisconsin. Funds would be obtained from revenue bonds and offered at an interest rate of 1% above the cost of capital.

The Editors would like to encourage physicians to contribute to the LETTERS TO THE EDITOR section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Now comes the carrot: Students would be eligible for partial forgiveness of loan indebtedness of up to $5,000 annually as follows:

(a) Up to $2,500 would be forgiven for each year a physician was involved in a primary care practice in Wisconsin, *ie,* family practice, general internal medicine, or general pediatrics.

(b) Up to $2,500 would be forgiven each year for practice in a geographical area designated as underserved.

That adds up to quite a lot of assistance for someone who plans on doing primary care in an underserved area—but here's the catch: The rest of the student body will have to foot the bill! Costs of the forgiveness portion of the program would be offset by reductions in the state subsidies to the two medical schools. According to the draft proposal, "The reduction in the state subsidy to the UW Medical School would be determined by assuming an increase of tuition levels from 16% to 33.3% of instructional costs for Wisconsin residents and from 28% to 50% in instructional costs for out-of-state students."

And "capitation funding support provided to MCW for Wisconsin residents would be reduced by an amount equal to the per capita reduction in state funding provided to the UW Medical School."

It doesn't take much of a mathematician to put two and two together and come up with a major increase in tuition which would in effect be subsidized by those students who choose not to enter primary-care fields in underserved regions of Wisconsin.

There are many reasons why the proposal should die quickly and mercifully. First of all, it is grossly unfair to all of the students and amounts to little more than extortion. A physician in bondage would be a poor bargain for his community even if he could be coerced into

continued on page 14

Generics save money. Big money!

The FTC estimates that $400 million could be saved annually on the nation's Rx bill if physicians prescribed generics. Are you saving *your* patients extra dollars?

Purepac, America's leading manufacturer of a national brand of generics, would like to show you the tremendous savings possible with just three of our 700 generic products:

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Purepac Meprobamate	400 mg.	1.85	**6.30**	77.3%
Librium Capsules*	10 mg.	8.76		
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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1979

1 Health Care Coalition
1 Women's Health Issues Post Conference Committee
1 Dane County Medical Society Board of Trustees
2 SMS Commission on Governmental Affairs
2 SMS Committee on Federal Legislation
3 Executive Committee of American Cancer Society-Wisconsin Division
3 SMS Specialty Section on Resident Physicians
4 Aesculapian Society
4 WisPRO Ancilliary Services Review
7 Dane County Medical Society HMP Committee
9 *Finance Committee of SMS Council (Milwaukee)*
9 *Executive Committee of SMS Council (Milwaukee)*
9 *SMS Council (Milwaukee)*
10 *WisPRO Annual Meeting (Milwaukee)*
10 *SMS Annual Meeting (Milwaukee)*
10 *SMS Specialty Sections Delegates Caucus (Milwaukee)*
10 *SMS House of Delegates First Session (Milwaukee)*
10 *Open Hearings, AMA Delegates (Milwaukee)*
10 *House of Delegates Reference Committee Meetings (Milwaukee)*
11 *SMS Specialty Section on Resident Physicians (Milwaukee)*
11 *Wisconsin Society of Radiation Oncology (Milwaukee)*
11 *Wisconsin Review Foundation (Milwaukee)*
11 *WisPRO Board Annual Meeting (Milwaukee)*
11 *SMS House of Delegates Second Session (Milwaukee)*
11 *Wisconsin Society of Plastic Surgeons (Milwaukee)*
11 *SMS Annual Meeting (Milwaukee)*
11 *SMS Auxiliary Annual Convention (Milwaukee)*
12 *SMS Specialty Sections on Ophthalmology, Anesthesiology, Pathology (Milwaukee)*
12 *SMS House of Delegates Third Session (Milwaukee)*
12 *SMS Annual Meeting (Milwaukee)*
12 *Aesculapian Society (Milwaukee)*
12 *Wisconsin Radiological Society (Milwaukee)*
12 *Wisconsin Allergy Society (Milwaukee)*
12 *Wisconsin Chapter, American College of Emergency Physicians (Milwaukee)*
12 *Wisconsin Neurological Society (Milwaukee)*
12 *Wisconsin Orthopaedic Society (Milwaukee)*
12 *Wisconsin Surgical Society (Milwaukee)*
12 *SMS Auxiliary Annual Convention (Milwaukee)*
12 *SMS Council (Milwaukee)*
14 Physicians Task Force, Health Planning Council
18 SMS Physicians Alliance Commission
25 Annual Meeting Scientific Planning for 1980
31 WisPRO Field Operations Staff

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis. ■

accepting the deal. The community might well be better off without him. It is doubtful that any small town will be able to attract a well-qualified graduate anymore. There just wouldn't be enough of a challenge to keep him sharp. Very soon he would be frustrated and "play out his option" and sign on at the regional health center in spite of the loss of his subsidy. Governmental interference in the settlement of physicians and their families is about as practical as planting palm trees in International Falls and ordering them to grow.

Also, if passed, the proposal would only add to the overwhelming debt of the average Wisconsin medical student. Very few parents would be able to afford the luxury of a medical student in the family. Only the wealthy students and the totally disadvantaged would apply, further lowering the quality of the applicant for admission to medical school.

Students now enrolled in both medical schools are worried about the proposal, and so are the faculties. If you share their concern, why not make your feelings known?

WAYNE J BOULANGER, MD
Milwaukee, Wisconsin

* * *

THERE ONCE WAS AN old WWI ditty entitled "How You Going to Keep Them Down On The Farm After They've Seen Paree?" This has now been updated to "How You Going to Keep Them Down on The Farm After They've Seen The Farm?" Unfortunately the latter applies to the placement of physicians in some of the less desirable areas within a city or out in the country.

The problem was publicized recently following a two-pronged legislative proposal. One of the proposals was approximately to double the medi-

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cal school tuition for Wisconsin residents to replace state funds in the medical school budget. The second aspect of the proposal was to make available to medical students a forgiveness feature for practicing in underserved areas of the state.

At the press conference where the proposals were presented, the legislative sponsors used some figures that proved to be quite inaccurate. These sponsors stated that up to 80% of the medical school graduates left the state after graduation and that most of those who stayed in the state practiced in larger cities. They also claimed that many entered highly specialized practices rather than providing for primary care. The spurious retention figures showed a steadily deteriorating picture.

Accurate figures from the University of Wisconsin Medical School present quite a different picture. First of all, the percentage of retention varied from a low 37% to a high of 43% and a consistent 42 to 43% retention in four out of five years surveyed. Actually the lowest retention rate was ten years ago. This would indicate that the retention of graduates has not been deteriorating despite the inaccurate press release. (MCW has a steady 37% retention rate.)

Even more encouraging is that between 1967 and 1978 the percentage of UW medical school graduates taking postgraduate training in Wisconsin had increased from 7.7% to 37%.

As for distribution, the UW graduate showed 13% practicing in communities of less than 5,000, 33% in communities of less than 20,000 and 50% in communities of less than 50,000. Also, 25% of the graduates are in a primary care specialty and 14% are in internal medicine. Thus close to 40% are practicing in a primary care specialty.

As for the proposed sharp increase in tuition, this would probably serve only to discourage a number of qualified students from even applying for entrance to medical school. As the Editor of the *Wisconsin State Journal* in Madison concluded in a succinct editorial: "Wisconsin offers a great deal for any prospective worker, doctors included, and will get its share of good people, doctors included. It doesn't have to resort to a higher tuition schedule to force medical graduates or anyone else to conform to legislative idea of what is good for the state—or them."

VICTOR S FALK, MD
Edgerton, Wisconsin

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Tuition facts and opinions

ALTHOUGH STATE LEGISLATORS have deferred their proposal for major tuition increases in the medical school until 1982 and 1983, their principle is unchanged. Wisconsin already has one of the highest tuitions of all US public medical schools.

In 1979 there were 53 public medical schools in the United States with tuitions less than Wisconsin. There were only 13 with tuitions higher. These ranged from a low of no charge at the University of California-Irvine up to a high of $4,000 in New Jersey and South Dakota. The Wisconsin charge for 1979 was $2,500 for a resident medical student.

It is interesting in looking over the schedule of tuitions to note that the six medical schools in Texas range from $267 to $400 for a year's tuition. The schools in California range from 0 to $812. Closer to home the medical schools in Illinois, Indiana, Iowa, Ohio, Michigan, and Minnesota also are lower than Wisconsin.

The legislators point out that the State spends about $13,000,000 a year on medical school education or an average of about $10,000 per student per year. They question what the State gets in return for this substantial investment. Although they indicate that two-thirds of the state medical school graduates leave Wisconsin after graduation, this figure is not entirely accurate. They also are concerned that many of these graduates who stay in Wisconsin go to large cities where they are not needed and often are in highly specialized and lucrative practices. They believe that the average medical student comes from a family of above average income and that as a doctor he will earn an average annual income of $75,000.

If the proposed legislation becomes effective, the present resident Wisconsin tuition to medical school will be doubled from $2,500 to $5,000 per year. This would make it the highest tuition for a public medical school in the entire nation.

The legislators also presented figures of retention of medical school graduates by states contiguous to Wisconsin. The University of Illinois through 1973 had 42% retention in that state and the other schools in Chicago range down to a low of 18% at the University of Chicago-Pritzker. The University of Iowa medical school had 32% retention and University of Michigan 42%. Michigan State University had 39% retention. Wayne State in Detroit had 59% and University of Minnesota in 1978 had 46%. The recent classes in the University of Wisconsin are showing retention rates of better than 40%, and there is no evidence that retention is deteriorating.

The indexing of tuition to anticipated future earnings is without precedent. It will not accomplish the goals of distributing physicians to underserved areas and to primary-care specialties. It is also fallacious to believe that family practice is the only discipline that will produce physicians for underserved areas. The proposed legislation could well be counterproductive by discouraging medical school applications with the prospect of massive indebtedness that they will undoubtedly incur, as opposed to students going into high-income professions other than medicine.

VICTOR S FALK, MD
Edgerton, Wisconsin

Safe Transportation

WHEN I BECAME SECRETARY of the Department of Transportation (State of Wisconsin), I became aware of the Committee on Safe Transportation of the State Medical Society and the service it has given to the Department over the past 10 years or more.

I want you (James L Weygandt, MD, chairman, Committee on Safe Transportation), the Committee and the Society to know that your efforts are sincerely appreciated. Your contribution has been an immense help to us in developing what we believe to be an effective and equitable program of medical screening of driver license applicants.

I would like to ask that the Committee continue to function in an advisory capacity, continuing to assist us in updating our medical standards and any other medical aspects related to driver licensing.

Please accept this letter as a notice of official appointment of the Committee to continue to act as an Advisory Board to the Department of Transportation. Authority for this appointment is contained in s.s. 15.04(3) of the Wisconsin Statutes.

LOWELL JACKSON, *Secretary*
Department of Transportation ■

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GENERAL ELECTRIC

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Annual edition devoted to medicolegal, socioeconomic, legislative matters of direct concern to the physician in his relationship to patients, hospitals, government agencies, the Legislature, and others in the medical community . . . a useful reference source throughout the year.

Legal responsibilities of the physician-patient-hospital relationship

SEVERAL QUESTIONS pertaining to the physician-patient-hospital relationship were addressed by the Society's legal counsel. The questions and excerpts from the opinion of legal counsel are presented below.

1. Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover or govern the question set out above. The basic statutes on hospitals relate to construction, safety, standards of maternity departments, and licensure.

In general terms, the courts have held that a physician has a legal responsibility to his hospitalized patient to furnish that degree of professional skill which meets the standard of professional care and to give such professional attention to the patient as the case requires. A physician is not legally excused for inattention to one patient on the grounds that he was occupied with the needs of others.

A physician has a continuing responsibility to his hospitalized patient at least to the point where the latter is well enough to be discharged, or sooner leaves without the physician's authorization. A physician may be charged with abandonment for neglecting a patient who needs his care, whether during or after hospitalization. Once a physician has agreed to care for a particular patient, he must continue to do so until the patient discharges him or no longer needs his professional services. He may be legally liable for neglect of the patient, or for ceasing to care for him until another physician has replaced him, unless he has been clearly discharged by the patient before the relieving physician actually takes over.

While a hospital nurse or technician may technically be in the employ of the hospital, a physician may incur legal liability for permitting a nurse or technician to carry out his treatment orders or assist him when he knows or has reasonable cause to know that such person is unsuitable for such duties by reason of inadequate training, experience, judgment or personality defect.

The essence of negligence is the absence of the degree of care owed by one person to another. Legal liability results when negligence causes physical injury or monetary damage to the object of such negligence. The principles of law involved are few, but their application depends upon the facts of the case, frequently as evaluated by expert testimony, and as found by a jury or court.

There also has been a recent trend toward the definition and codification of social or human rights of patients apart from their right to receive care meeting the appropriate standards of professional skill. A patients' bill of rights for nursing home and residential care facility residents has been enacted both by statute and administrative rule. Several hospitals have adopted or considered such a statement of rights. While not affecting the nature of care given, this expression of patients' rights does affect the environment within which this care is provided.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts in the past tended to distinguish the *administrative* negligence of a hospital from the *professional or medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital was liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

The distinction between the administrative and housekeeping functions for which hospitals were traditionally responsible and professional activities for which the physician was responsible has become blurred. Institutional liability for the negligence of its paraprofessional employees, frequently joint liability

with independent physicians who are their immediate supervisors, is well settled. The 1965 *Darling* case in Illinois voiced a responsibility of the hospital to review and supervise the care given in the hospital. That case rested in part on the failure of hospital employees in observation and reporting but the principle established was broader. In other recent cases courts have held that hospitals may be liable for admitting incompetent practitioners to their medical staffs, for the failure of medical staffs to supervise physicians practicing in the institutions, and for not establishing quality review systems. While these all have administrative aspects, they also put the hospitals into potential jeopardy for the quality, or lack of quality, of care provided in the institution. Thus both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff and to some extent the care given in the institution. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to determine during the course of the trial that no liability exists against one or more of the parties sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility*. It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. So long as a contract between such a specialist and a hospital relating to his practice is in accordance with the fee splitting statute and other applicable laws, it is enforceable by him against the hospital and by the hospital against him.

The second area of legally enforceable rights enjoyed by staff physicians are those which relate to staff privileges as such. The documents which govern staff privileges are typically bylaws, rules and regulations, the application of an individual physician for staff privileges and the official action on such application, first, by the medical staff, and then by the governing body of the hospital. A physician whose staff appointment is regular in every respect acquires legally enforceable rights once he becomes a member of the medical staff. Those rights depend upon and are limited by the provisions of the hospital bylaws, rules and regulations, and by any particular conditions attached to his appointment, such as limitations on surgical privileges.

It is the proper business of the individual and collective membership of a medical staff to see that the granting of staff privileges, their limitation, suspension and termination are spelled out clearly, adequately and fairly. This is a matter of proper concern to patients whom the physician may hospitalize, and of enlightened self-interest to physician and hospital as well.

There appears to be a trend generally in the courts of this country to recognize something akin to a property right in hospital staff privileges *once they are granted,* so long as they remain in force, and assuming that the physician is not guilty of acts of professional negligence

or misconduct. This means that the trend of the courts is away from permitting summary suspension or termination of staff privileges without a fair hearing, except for grave cause which might endanger patients or create liability on the part of the hospital.

Increasing importance should be attached to "negotiations" between the medical staff and the governing body or administrator of a hospital. These can be conducted by the Chief of Staff of a very small hospital, or by the Executive Committee of the medical staff of a larger hospital, in areas in which patient welfare and safety are involved, or in which tensions or conflict may arise between hospital policy and medical policy to the detriment of patient welfare. The latter are not matters of contract right as such, but are akin to "collective bargaining", and become a matter of understanding at the point the hospital and the medical staff are in agreement. They might include such areas as the unwillingness of the governing body of the hospital to follow medical staff recommendations for granting or limiting staff privileges; failure to purchase desirable or needed equipment or to replace equipment in the interests of patient safety or welfare; inadequate selection of the nursing, technical and other staffs of the hospital, or insufficient supervision and continued training during the course of employment. ■

EDITORIAL

An effective AMA tool for medical society PR

We in medicine are in dire need of good public relations at a time when assault after assault on our profession is made in the name of the public.

But just what is good PR?

It's more than getting our message across to the people. It demands the development of reciprocal understanding between the public and ourselves.

Gaps in understanding exist now. Recent opinion surveys indicate that in general the public perceives one set of problems in health-care delivery, while physicians perceive a different set.

So how is reciprocal understanding achieved? Our main thoroughfare to it is good relations with the press, television, and radio, because they afford the only practical communicative access to the public at large. And, they regard themselves as its voice.

Accordingly, the AMA has just come out with the third printing of its booklet, *You, Too, Can Have a Good Media Relations Program,* which is beamed especially at county medical societies.

As the booklet notes, counties "are the most intimate points of contact between organized medicine and the people."

The publication says it is important to understand the nature, needs, and methods of the media's news operations and to establish personal familiarity with media representatives.

Asserting that "true knowledge of the media must begin with an open mind," it comments:

"It is easy to write (them) off as biased against organized medicine and physicians . . . It is easy to suppose that any efforts to deal with the media are doomed in advance.

"Such an attitude is largely wrong. And certainly it is self-defeating."

As a first rule in implementing a media-relations program, the booklet urges medical societies to treat all the media with the fairness that is expected from each of the media.

It gives pointers on developing a news sense, preparing "to-the-point" news releases, arranging news conferences, and countering unfavorable news and views.

For its own part, the AMA is intensifying its efforts in such directions as public-service announcements and programs for TV and radio and features for newspapers. But it is also stepping up its PR consultation services for state and county societies, background information services for society editorials, and so forth.

To enhance our public relations, our federation has to work interrelatedly at all levels—county, state, and national. For there is only one American public. Contact the AMA's Office of Public Relations for copies of this timely publication.

MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

13. Cancer?

Yes, to the Department of Health and Social Services.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. But see article on page 68 of the June 1974 Blue Book issue.

17. Drug addiction?

No.

18. Abused or neglected children?

Yes. The law requires reports of "abused" or "neglected" (those not receiving food, clothing, shelter or care, including medical care so as to "seriously endanger" the child's health) children or those with exceptional educational needs (see article page 28). Wilful failure to report may subject a physician to a penalty; good faith reports provide immunity.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

Physician and Hospital Records: Retention and Inspection

A. Retention of Records

It is generally agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. Their beneficial ownership, that is the right to have them used for one's benefit, is in the patient although the right to possession remains in the physician or hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* on this subject in 1959, which was reprinted in full in the June 1975 BLUE BOOK issue of the *Wisconsin Medical Journal.* (74 *WMJ* 30)

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted in 1959. Subsection (4) in revised form has been renumbered 804.10 (4) Wisconsin Statutes, and became effective January 1, 1976. It is reprinted in the box accompanying this article.

It should be emphasized that parts of the *Interpretation* are no longer relevant because of intervening amendments to the 1959 statute. Its principal value was that it represented the joint thinking of the State Medical Society and the Wisconsin Hospital Association, acting through their respective governing bodies and officers. Where there is a difference between the wording of the *Interpretation* and this article, the article governs.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related reports, but such additional items as: x-rays, laboratory reports, notations directing or evidencing treatment given, and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.
2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers,

within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.

C. If the patient is a mentally normal minor at the time of treatment or hospitalization, suit for injuries resulting from alleged malpractice by a health care provider must be brought on behalf of the minor within the later of: (i) 3 years after the injury or (ii) the time the minor reaches the age of 10.

D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 19. If such patient remains mentally ill after reaching age 18, his guardian must start suit within 8 years of the alleged negligence, or before the patient is 19, whichever date occurs later.

4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;

2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

B. Inspection and Copying of Medical Records and Reports

Both the old and revised subsections limited the right to inspect and copy medical or hospital records and reports to situations where *no litigation* is pending respecting the medical care and treatment covered by the authorization. Once litigation is begun, situations involving the inspection or copying of medical records and reports are governed by other statutes. The revised text of the subsection, renumbered as 804.10 (4), which took effect January 1, 1976, is set out in the box on page 27 of this article.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have

STATUTE

Former Section 269.57 (4) of the Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization was revised and renumbered as of January 1, 1976, to read:

> "804.10 (4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

NOTES: The principal differences between the old and new statutes are:

1. The earlier statute permitted the inspection and copy on the written authorization of a patient or his representative of "any medical or hospital reports, photographs, records, papers and writings concerning [his] care or treatment."

The revised subsection imposes narrower requirements limited to "medical or hospital records or reports."

2. Former Section 269.57 (4) provided that a custodian of medical or hospital records who refused to comply with an authorization submitted by or on behalf of a patient was liable to such patient "for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs."

Section 804.10 (4) provides that such custodian "shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover." This is a much more severe penalty.

the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identify of a person presenting authorization to inspect or copy records, the physician (or his representative) or the hospital (or his representative), depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the authenticity of the signature or the mental capacity or age of the patient.

The statute authorizes the personal representative, or the beneficiary of a life insurance policy, to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Domiciliary Letters" or other documentary evidence of appointment or authorization which are issued by the Circuit Court branch handling probate matters.

In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) the person signing the authorization is the beneficiary under the policy.

The burden of proof is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized. On being satisfied that the authorization presented is properly signed, as previously outlined, that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the physician or hospital to permit such person to inspect and copy "any medical or hospital records or reports concerning" the care or treatment designated in the authorization. Exactly *what* records and reports may be inspected and copied is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be made available for inspection and/or copying.

It is believed that under a fair interpretation of subsection (4) the physician's records and reports (office or hospital), and the hospital clinical record or chart should be made available for inspection or copying.

In the case of x-rays there seems to be some disagreement among legal authorities as to whether they are part of the medical record as such, or are technically photographs. It is advised that x-rays be inspected *only* under proper supervision, in the case of a physician's office by the physician in charge, an associate, or the designee of either, in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator.

X-rays must *not* be taken from the office of a physician or other custodian unless required by a court order or subpoena. When either of the latter is served on the custodian of medical records or reports, Section 804.10 (4) *is no longer applicable,* and the authorization is no longer in force.

One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional responsibility of the attending physician and of those acting under him, and may be described as the "official records and reports". The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care or treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. The statute does *not* require a physician or hospital, to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

As a final observation, although legal title to medical records and reports is in the physician or hospital, depending on their location, the general legal opinion is that such records and reports are held in the custody of the physician or hospital for the benefit of the patient. It is on that basis that they are made limitedly available to him or to persons designated by him. ■

MALPRACTICE PENALTIES FOR THE UNLICENSED

Section 448.12 of the Wisconsin Statutes, quoted below, is concerned with legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 448.12 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the sick without having a license or a certificate of registration, shall be liable to the penalties and liabilities for malpractice; and ignorance shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

CHILDREN WITH HANDICAPS:
To refer or not to refer

In 1973 the Wisconsin Legislature passed a comprehensive law concerning the education of children with handicaps. This law is now incorporated into the Wisconsin Statutes in Chapter 115. It covers many activities at the state and local levels concerned with educating children who need special arrangements in order to benefit from schooling.

The framers of the legislation wanted to make sure that all children who might have difficulty obtaining an appropriate education were brought to the attention of the school district. Therefore, they made it mandatory for certain persons (physicians being one group) to refer such children. Section 115.80 (1) (a) says in abridged fashion:

> "A parent or a physician, nurse, etc. . . . who has reasonable cause to believe that a child brought to him or her for services has exceptional educational needs SHALL report the name of the child and any other information required to the school board for the district . . . and (c) before any report is made under this subsection, the person making the report shall inform the child's parent that the report will be made."

According to this statute then, physicians are required to refer children to the school district if they believe the child may need special arrangements in school. A child with exceptional needs is defined in section 115.76(3) as

> —any child who has a mental, physical, emotional or learning disability which, if the full potential of the child is to be attained, requires educational services to the child to supplement or replace regular education . . .
> (a) physical or orthopedic disability
> (b) mental retardation or other developmental disability
> (c) hearing impairment
> (d) visual disability
> (e) speech or language disability
> (f) emotional disturbance
> (g) learning disability, etc.

There may be physicians who feel that this is just another example of the Legislature trying to control medical practice, but before expressing too many negative feelings consider the reasons for the law:

1. Until this law was passed, school districts could say that they had no program for a particular child, thus denying that child an education. Now they must serve all children over age 3 and through age 21.
2. Children with disabilities will have less of a handicap if education can be started early. This is especially true of children with neurological deficits, blindness and deafness.
3. School boards must plan for the education of all children in their district and it helps them to know what kind of children are in the district.

There may be parents who do not understand the advantages of early planning or programming of a child with a possible handicap. The law states that the parents must be told about the referral but their permission is not necessary. However, most physicians will want to discuss this with them and point out the advantages to be gained and tell them the process the school will use to evaluate the child.

What is going to happen when a child is referred to the school board because of a suspected exceptional education need (EEN).

1. The law says that for children over age 3, the school board MUST evaluate the child and if found to be in need of special education, place the child in a program within 90 days of the referral. The parents will receive a formal written notice asking permission to schedule the child for an evaluation by a school multi-disciplinary team—known as the M-team. Any information you can supply to the school about the condition of the child will assist in the evaluation and should be sent with the referral. In complicated cases it might be helpful for the physician to join in a discussion with the members of the M-team and it would be appropriate for you to offer this or for them to ask.
2. If the M-team determines that the child does have an exceptional educational need, he/she will be placed in an appropriate program by the director of special education or the district's program designee.
3. If the parent does not agree with the placement, the law outlines specific steps for appeal.
4. If the child is found not to have an exceptional educational need, he/she will be placed in a regular educational program, if age 5 or older. This decision is also appealable.
5. If the child is under 3 years of age, the law states the school MUST *SCREEN* the child if the parents request it, but they are not mandated to evaluate the child or provide a program. Even so, some school districts do have programs for children under 3 years of age, especially those with neurological damage, blindness or deafness and, therefore, it is well to refer these children as soon as the diagnosis is evident.

This law is designed to assure that children who need special help in school get that assistance. Refer children you suspect of having an educational problem, send them the results of your evaluation, and let the school decide on the educational program most appropriate.

—HORACE K TENNEY III, MD
Bureau for Crippled Children
State of Wisconsin
Madison ■

Reports on abused children and those with special educational needs

The Abused Child Law:

How it affects you

ABUSE OF CHILDREN by parents and others can be found at all economic, educational and social levels. The cumulative effect of repeated beatings or other forms of severe abuse, which may include physical crippling, brain damage or even death, must be prevented.

The Legislature has strengthened prior law making reporting of suspected cases of child abuse mandatory to physicians and adding a wide variety of persons dealing with children who are required to report cases of suspected child abuse. The Legislature further provides that the reports be made to the city police departments, sheriffs, and county child welfare agencies. The law grants civil as well as criminal immunity from suit where a report is made in good faith. Child abuse has been made a Class E felony (punishable by a fine up to $10,000 and imprisonment up to two years).

The actions of the Legislature have immeasurably increased the probabilities that perpetrators of abuse will be identified and will receive rehabilitative help while the abused child will be extended protection from further abuse.

The Law

Relevant portions of the law, quoted from the Wisconsin Statutes, follow:

48.981 Abused or neglected children. (1)

DEFINITIONS. In this section:

(a) "Abuse" means any physical injury inflicted on a child by other than accidental means, or sexual intercourse or sexual contact under s. 940.225. In this paragraph, "physical injury" includes but is not limited to severe bruising, lacerations, fractured bones, burns, internal injuries or any injury constituting great bodily harm under s. 939.22 (14).

(b) "Child" means any person under 18 years of age.

(c) "County agency" means the county child welfare agency as defined in s. 48.56 (1).

(d) "Neglected child" means a child whose parent, guardian, legal custodian or other person exercising temporary or permanent control over the child neglects, refuses or is unable for reasons other than poverty to provide necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child.

(2) PERSONS REQUIRED TO REPORT CASES OF SUSPECTED CHILD ABUSE OR NEGLECT. A physician, coroner, medical examiner, nurse, dentist, chiropractor, optometrist, or any other medical or mental health professional, social or public assistance worker, school teacher, administrator or counselor, child care worker in any day care center or child caring institution or police or law enforcement officer having reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected shall report as provided in sub. (3). Any other person having reason to believe that a child has been abused or neglected may make such a report. No person making a report under this subsection may be discharged from employment for so doing.

(3) PROCEDURES. (a) *Initial report.* Persons required to report under sub. (2) shall immediately contact, by telephone or personally, the county agency, sheriff or city police department and shall inform the agency or department of the facts and circumstances contributing to a suspicion of child abuse or neglect. * * * The county agency may require that a subsequent report be made in writing.

(b) *Duties of local law enforcement agencies.* 1. Any person reporting suspected abuse or neglect of a child may request an immediate investigation by the sheriff or police department if the person has reason to believe that the child's health or safety is in immediate danger. Upon receiving such a request, the sheriff or police department shall immediately investigate to determine if there is reason to believe that the child's health or safety is in immediate danger and take any necessary action to protect the child. * * *

(c) *Duties of county agencies.* 1. The county agency shall act in accordance with s. 48.57. Within 24 hours of the receipt of an initial report of suspected child abuse or neglect, the county agency shall commence an appropriate and thorough investigation to determine whether the report is "indicated" or "unfounded." The complete investigation shall, if possible, include a visit to the child's home or usual place of abode, observation of the child and an interview with the child and the child's parents or custodians.

2. Additionally, within 72 hours after receipt of an initial report the county agency shall complete and forward to the department under sub. (7) a preliminary investigative report containing the name, address, age and sex of each child involved and the type of abuse or neglect suspected. The preliminary report shall not contain any information which identifies any person other than the child. * * *

7. The investigator shall inform any person required to report suspected cases of child abuse or neglect that the report was unfounded or that steps were taken to protect the health and welfare of a child who is the subject of a report made by the person. At least one

contact shall be made under this subdivision within 60 days after receipt of the initial report by the agency. * * *

(4) IMMUNITY FROM LIABILITY. Any person or institution participating in good faith in the making of a report, ordering or taking of photographs or ordering or performing medical examinations of a child under this section shall have immunity from any liability, civil or criminal, that results by reason of the action. For the purpose of any proceeding, civil or criminal, the good faith of any person reporting under this section shall be presumed.

(5) CORONER'S REPORT. Any person or official required to report cases of suspected child abuse or neglect who has reasonable cause to suspect that a child died as a result of child abuse or neglect shall report the fact to the appropriate medical examiner or coroner. The medical examiner or coroner shall accept the report for investigation and shall report the findings to the appropriate district attorney, the department, the county agency and, if the institution making the report initially is a hospital, to the hospital.

(6) PENALTY. Whoever wilfully violates this section by failure to file a report as required, may be fined not more than $100 or imprisoned not more than 6 months or both. * * *

(10) CONFIDENTIALITY. (a) 1. All reports and records made under this section and maintained by the department, county agencies, the central registry and other appropriate persons, officials and institutions shall be confidential, except that confidentiality of and access to preliminary investigative reports maintained by the department shall be governed solely by sub. (7). [access by county agencies] * * *

(b) Any person who violates this subsection, or who permits or encourages the unauthorized dissemination or use of information contained in the central registry and in reports and records made under this section may be fined not more than $1,000 or imprisoned not more than 6 months or both.

(11) EDUCATION, TRAINING AND PROGRAM DEVELOPMENT AND COORDINATION. (a) The department and county agencies to the extent feasible shall conduct continuing education and training programs for state and county department staff, persons and officials required to report, the general public and others as appropriate. * * *

940.201 Abuse of children. Whoever tortures a child or subjects a child to cruel maltreatment, including, but not limited, to severe bruising, lacerations, fractured bones, burns, internal injuries or any injury constituting great bodily harm under s. 939.22 (14), is guilty of a Class E felony. In this section, "child" means a person under 16 years of age.

Your responsibility

Physicians and surgeons and others with reporting responsibility are to make their initial reports immediately by phone or in person to the proper office or official. The county agency may require a followup report in writing.

The county agency investigating the report of suspected child abuse must inform the person making the report whether the investigation showed no evidence of abuse or what steps were taken to protect the child.

If there is suspected abuse in connection with the death of a child, a report must be made to the coroner or medical examiner.

Reports under the law are confidential. Wilful failure to report as required may bring a fine of up to $100 and imprisonment up to six months.

Governmental responsibility

The first responsibility of the county agency is to see that the child is safe while a complete investigation is made. It then conducts an investigation to see if neglect or abuse exists. If abuse is found, the decision then must be made how best to protect the child. This may involve parental counseling, temporary or permanent removal of the child from the home.

Exceptional educational needs

Physicians, among others, are required to report to the local school board or the Division for Handicapped Children of the State Department of Public Instruction the name of any child brought to them for services who they have reasonable cause to believe has exceptional educational needs. Such children include those with physical or orthopedic disabilities, mental retardation, developmental disabilities, hearing impairment, visual disability, speech or language disability, emotional disturbance, learning disability or pregnancy. The Superintendent of Public Instruction may add to these conditions and physicians should report all cases in which a mental, physical, emotional or learning disability is such that the child will require special educational services to attain full potential. Before any report is made the parents of the child must be informed it will be made. ■

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin. If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Section 979.125, Wisconsin Statutes, adopted in 1978, requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

MEDICOLEGAL FIRST AID

THE CONTINUING AND RAPID scientific advances coupled with the increased demands and expectations of patients frequently results in an imbalance between the art and science of medicine. A proper blending of the art and science by the practicing physician and his associates contributes much in the way of patient and professional satisfaction. From all the Council's Committee on Economic Medicine can ascertain, the professional liability insurance market is less restricted in Wisconsin than it is in several other jurisdictions. Even so, SMS members are required to pay substantial premium rates for this protection which is so essential to the practice of medicine. The Committee on Economic Medicine continues its efforts to keep abreast of developments in this important area and offers the following points to physicians.

I. Keep your expired professional liability policies

Comment: The standard three-year Statute of Limitation is not applicable to minors or incompetents. You may be sued many years after the alleged event. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

II. Keep good records and retain them for years

Comment: See Comment to No. I. In any event retain records in *all* cases for a minimum of six (6) years after date of last treatment. As to the special situations presented by minors and the mentally ill or incompetent, see your personal attorney.

III. Advise patients as to risk involved in not only operative procedures, but also as to side effects of drugs prescribed or administered; this is frequently called "Informed Consent"

Comment: The legal test appears to be "What would the average prudent person in the patient's position have decided if informed of the perils?" No longer is the legal test what the *physician* believes the patient or his representative should know about the risks of the patient.

IV. The "Locality Rule" has been abolished in Wisconsin

Comment: The practitioner be he "generalist" or "specialist" is now subject to liability in an action for negligence if he fails to exercise that degree of care and skill which is exercised by the average practitioner in a class to which he belongs, acting in the same or similar circumstances. Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate.

V. Continued membership in your Society is recognized by the Courts as vital for continuing education

Comment: The Courts state that there is no lack of opportunity to keep abreast of the advances made in the medical profession and cites the AMA JOURNAL as authority. The same reasoning applies to SMS JOURNAL and the Society's continuing education programs.

VI. Refrain from ill-advised remarks; THINK BEFORE YOU SPEAK

Comment: Many of the malpractice cases have their genesis in the unfortunate thoughtless spontaneous statements of a nurse, a technician or a physician. Warn your employees and assistants to be on the alert at *all* times.

VII. Give prompt notice to insurer in the event of an "incident"

Comment: Should there be any occurrence in the patient-physician relationship which might result in either a claim or litigation, give prompt notice to the carrier. Timely notice and prompt investigation are far superior to waiting for a formal summons.

VIII. Provide Continuity of Care

Comment: Once a physician accepts a patient which requires a course of treatment he should pursue the plan of prescribed care. If the physician is to be out of the area for an extended period he should arrange for suitable coverage and so notify the patient. Should the patient fail to complete the prescribed plan of care, the physician should follow-up and; in either event this should be documented in the patient's record.

IX. Be alert to the suit-prone "litigious" patient

Comment: Some patients have a tendency to be hypercritical of physicians who have previously treated them. Others may have unrealistic expectations of good or perfect results of medical care. In such situations, extreme caution should be exercised so as to minimize the probability that you or a physician who has treated the patient previously will become involved in a liability claim or suit.

X. Avoid discussion of your liability insurance

Comment: The knowledge that you carry insurance *may* precipitate a claim should an unanticipated complication arise or if the patient becomes dissatisfied with the results of a course of treatment.

XI. Always exercise discretion in the collection of accounts

Comment: All patient accounts should be reviewed before being turned over to a collection agency, and special consideration should be given to the accounts of patients who have evidenced any degree of dissatisfaction which might become the basis for a counter charge in the form of a suit against the physician. While the physician is entitled to remuneration for professional services rendered, foregoing payment may be less of a loss than being a defendant in a lawsuit.

XII. Avoid direct contact with a plaintiff's attorney

Comment: In the event of a claim or suit and the plaintiff's attorney attempts to contact you, you are well advised to refer him to your own attorney. Any communication you may have with a plaintiff's attorney — no matter how well intentioned — might very well compromise your defense if the case proceeds to litigation.

The Committee on Economic Medicine will continue to monitor current literature relating to medical professional liability claims to ascertain additional factors which may give rise to suits against physicians. As they are identified, they will be communicated to you through the MEDIGRAM and in other ways. In the interim physicians are encouraged to communicate any helpful hints to the committee so they may be shared with your colleagues in furtherance of both the public and professional interest. ■

Some considerations in the closing of a physician's practice

WHILE THERE ARE NO formally slated rules for closing a medical practice, there are several important items which should be considered and planned in advance. The list given below is not complete but the State Medical Society of Wisconsin believes it will be helpful.

1. Notification of patients

Patients should be given adequate notice, a minimum of three months is suggested, in writing that you plan to close your office and on what date so that they will have sufficient time to obtain another physician. It is also suggested that, in the letter of notice to the patients, you enclose a form for the patient to sign authorizing the release of records should they wish to request that a copy of their records be sent to the new physician of their choice. A list of all patients notified should be retained in your files.

You can save postage, in the case of current patients, by inserting the letter with a monthly statement or billing; letters to other patients will have to be mailed separately.

You also may wish to place an announcement in one or more local newspapers.

2. Retention of medical records

(a) Medical records, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others, should not be destroyed for at least six years after you have seen the patient for the last time. This is because the physician's records and liability insurance policies could be your chief source of defense in a future law suit.

(b) The patient has a general right to know what is in his medical records and thus you should make it known where such records can be obtained. Such records generally should not be given to the patient, but should be forwarded to another physician of the patient's choice with the consent and at the request of the patient, in writing.

(c) Former Section 269.57 (4) of the Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization was revised and renumbered as of January 1, 1976 to read:

> "**804.10 (4).** Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

3. Disposal of drug stocks

The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, Post Office Box 28083, Central Station, Washington, D.C. 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Avenue, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

Instructions on the disposal of non-narcotic drugs in the possession of the physician may be obtained from the Wisconsin Pharmacy Examining Board, 1400 East Washington Avenue, Madison, Wisconsin 53702.

4. Sale of medical practice

(a) If you are selling your practice, you should make certain that the buyer is a physician licensed, or eligible to be licensed, in Wisconsin. This information can be obtained from the State Medical Society or the Wisconsin Department of Regulation and Licensing.

(b) Records relating to patients should not be sold. However, the sale may include, as one of its

terms, unlimited access to the records of those patients who seek the services of the purchasing physician.

5. Keeping your license in force

It is strongly recommended that you keep your license in force and register each year in the event that you wish to do some consultation work or are called upon to perform some act of medical practice in an emergency.

6. Malpractice insurance

Your policy should be examined to determine whether it is written on a CLAIMS INCURRED or a CLAIMS MADE basis. Consult your insurance agent. If the policy is written on a CLAIMS MADE basis, only those claims made while the policy is in force will be covered and you should either continue your coverage or purchase coverage extension to protect you until all statutes of limitation have run.

7. Accounts receivable

Not all of your patients will have paid their bills by the time your practice is closed. It will be necessary to have someone available to accept, record, and deposit payments received after the official closing of your practice. You may wish, after a suitable waiting period of three or four months, to turn those accounts still unpaid over to a reputable collection agency.

8. Continuation of SMS membership

We hope that you will continue to be active in the Society. This can be done by notifying your County Society, in writing, that you are closing your practice but wish to remain active in Society affairs. The County Society will notify you of its dues, if any, for inactive physicians. There are no dues for continuation of SMS or AMA membership in such cases.

Finally, it is recommended that you work closely with your attorney or business manager particularly on the tax aspects of closing your practice.

9. Income taxes

Copies of your income tax returns and all supporting documentation, including ledgers and accounting records, should be preserved until the Internal Revenue Service can no longer assess additional tax. For returns filed on time and containing all correct and pertinent data, this is usually three years; for returns where gross income has been understated by 20 percent or more, it is six years; for fraudulent returns or where no return has been filed there is no time limit. ■

PRINCIPLES OF ADVERTISING

Wisconsin Medical Journal

The acceptance of advertising in the *Wisconsin Medical Journal* is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Society of Wisconsin. The Journal reserves the right to accept or reject advertising copy *for any reason.*

The following general rules are applicable to advertisements of medicinal preparations, apparatus or physical appliances or other products for therapeutic or diagnostic purposes or for which therapeutic, diagnostic or health claims are made:

1. The advertiser may be required to submit evidence or data in support of the usefulness of the product and the validity of the claims. The appearance of one or several papers may not necessarily be considered sufficient evidence and other data may be required.
2. Medicinal preparations containing two or more active ingredients will be considered only if in the opinion of the Advertising Committee of the Bureau there is a logical rationale for the inclusion of each active ingredient, and if a statement of the active ingredients is included in each advertisement.
3. The generic or official designation of the medicinal preparation must be adequately featured in advertising copy, in addition to the trade name.

All advertising copy is subject to the following general rules:

1. Advertisement should not be false, deceptive or misleading nor make use of sweeping superlatives.
2. Unfair comparisons and disparagment of a competitor's goods will not be allowed.
3. When excerpts from a published paper are included in advertising copy, the Bureau may require the advertiser or his agent to obtain written permission from the author and from the editor or publisher of the publication in which the paper appeared.
4. Advertising copy will not be accepted if, in the opinion of the Bureau or the management of the medical journal, the copy (a) appears to violate the Principles of Medical Ethics of the American Medical Association or of a state medical association, (b) is indecent or offensive in any way, (c) contains attacks of a personal, racial or religious character, or (d) appears to be contrary to any regulation or law for the prevention of discrimination, or (e) contains claims found by any court or federal or state agency to be invalid or in violation of law.
5. Advertisers and advertising agencies agree to protect and indemnify both bureau and any medical journal represented by Bureau against any and all liability, loss or expense arising from claims for libel, unfair competition, unfair trade practice, infringement of trademarks, trade names or patents, copyrights or proprietary rights, violations of rights of privacy and any other claims resulting from any advertisement submitted to the Bureau or published in any such medical journal.

The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Oak Park, Illinois.

Let These Guides Help You

The following guides and manuals have been prepared or obtained at the direction of the Council and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept., State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

- **Guide to the Service Corporation Law**

- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.

- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.

- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.

- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Revised 1978—Single copy 25¢ with order.)

- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $1.00 with order.)

- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10" × 11 1/2". For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $11.00; complete guide without binder: $10.00—to accompany order.)

- **Physician and Hospital Records: Retention and Inspection**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.

- **Legal Responsibilities of the Physician-Patient Relationship.**

- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.

- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Written by Edmund S. Crelin and reprinted by permission of *American Scientist.*

- **Advertisements on Health Care Costs**—County Medical Societies may obtain upon request reproduction proof's on using health care costs for placement in their local newspapers.

- **Rubella—Red Measles Brochure**—This conveniently sized 2 1/2" × 4" sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.

- **To Your Good Health**—Explains the reasons behind rising health care costs and offers tips on how to save money on medical expenses.

- **Alcohol and Your Unborn Baby. . .**—Warns women of the harmful effects alcohol can have on an unborn child. Available in both English and Spanish versions.

- **To All My Patients, Partners in Good Health**—Explains the rights and responsibilities physicians and patients have in medical care. Available in standard brochure or smaller "statement stuffer" form.

- **I Want To Know What You Think**—a questionnaire physicians can use with patients to elicit their attitudes and opinions regarding his/her medical practice.

- **So You've Been Sued . . . Now What?**—a brochure prepared by the SMS Medical Liability Committee which answers 12 questions physicians commonly ask about medical malpractice lawsuits.

SPECIAL TO THE JOURNAL

How to get health-related information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee the Todd Wehr Library (Medical College of Wisconsin). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given below. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Midwest Health Science Library Network, which encompasses a six-state area, to the National Library of Medicine; and, if necessary, to the British Lending Library.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computer searches, including MEDLINE, can now be done at the resource libraries and at the Luther Hospital, Eau Claire; LaCrosse Lutheran Hospital; the Howard Young Medical Center, Woodruff; and St Mary's Hospital in Madison. If your local library cannot provide computer searches, it can forward any request to the most appropriate library in the network.

In most cases, the only charges will be for computer searches and for photocopies.

Medical Library Service
University of Wisconsin
Middleton Health Sciences Library
1305 Linden Drive
Madison, Wisconsin 53706

Medical College of Wisconsin
Todd Wehr Library
Box 26509
Milwaukee, Wisconsin 53226

■

Tenuate® Ⓒⓥ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® ©IV
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

Merrell

For prescribing information see opposite page.

new
600 mg tablets
Motrin®
ibuprofen, Upjohn

More convenient for some of your patients.

Now there are three Motrin tablet strengths to choose from–
600 mg, 400 mg, and 300 mg

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001, U.S.A.

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J-6999-4

A 1979

Guide to interpretation of the

CARDIAC STANDARDS OF SCHOOL BUS OPERATION

Prepared by the Committee on Safe Transportation and approved by the Council of the State Medical Society of Wisconsin, April 7, 1979

EXPERIENCE WITH MEDICAL reporting for school bus drivers has demonstrated some disagreement among physicians in the interpretation of the cardiac question, "Does subject have a current clinical insufficiency, thrombosis, or any other cardiovascular disease or condition known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure?"

Examples of applicants *certified* by the examining physician for school bus operation:

No. 163 67 yr M certified four months post aortic valve replacement; current medications: digoxin (Lanoxin®), furosemide (Lasix®), and warfarin (Coumadin®)

No. 183 53 yr M certified three months post multiple coronary bypass with abnormal postoperative stress test; medications: digoxin (Lanoxin®)

No. 192 66 yr M has angina "but is not fainting;" medications: "one pill a day"

No. 201 54 yr F heart attack 10 years ago; medications: furosemide (Lasix®), digoxin (Lanoxin®), clorazepate dipotassium (Tranxene®), and spironolactone (Aldactone®)

The following guidelines were developed by the State Medical Society's Committee on Safe Transportation, assisted by several cardiologists, in response to a request from the Driver Licensing section of the Wisconsin Department of Transportation. It is hoped that this interpretation of the standards for school bus operation (Wisconsin Administrative Code: Dept of Public Instruction PI 7.01) will assist examining physicians in advising their applicants and that sufficient detail will be reported to assist in the licensing decision.

These guidelines were approved by the State Medical Society of Wisconsin Council, April 7, 1979.

* * *

WISCONSIN ADMINISTRATIVE CODE

Rule PI 7.01 (1) (e) & (g), *Physical Requirements for School Bus Drivers*

1. General Considerations

A. The implications of a school bus crash are so great as to warrant establishment of very high medical standards for drivers thereof.

B. In general, a symptomatic cardiac condition is disqualifying. If the condition is asymptomatic, the burden of proof should rest with the applicant to demonstrate functional competency.

C. With regard to cardiac problems, it is generally accepted that only about one-half of the persons with sudden incapacitating events have any prior history of cardiac symptoms, hence standards regulating only persons with known heart disease cannot possibly prevent all such incidents.

D. The only accurate diagnostic technique presently available to assess coronary artery patency is coronary angiography. Such studies are considered inappropriate for screening purposes—as in periodic repeated examinations of asymptomatic persons to attempt to rule out all drivers with coronary artery disease.

E. It is not now considered reasonable to mandate coronary angiography for any persons, but the driver should have the choice relative to angiography in order to demonstrate his physical status and eligibility for certification. (See 3-B)

F. The cardiac drugs considered here are not believed to present a significant risk of impairment for driving from side effects, hence, detailed recording of dosages is not presently believed necessary.

2. Specific Cardiac Conditions

A. These conditions disqualify for school bus operation if currently present.

1) Cardiac pacemakers
2) Artificial heart valves of any type
3) Cor pulmonale
4) Cardiomyopathy—except when asymptomatic with normal resting and submaximal stress ECG
5) Syncope or presyncopal sensations (lightheadedness) within preceding five years, if related to a cardiac condition.

6) Symptomatic coronary artery disease (angina pectoris) (See 3-B)
7) Recurrent pulmonary emboli within preceding five years
8) Cerebral infarction
9) Transient cerebral ischemia (TIA)
10) Amaurosis fugax (transient blindness)
11) Meniere's syndrome or other recurring vertigo
12) Intracerebral or subarachnoid hemorrhage
13) Symptomatic orthostatic hypotension

B. Persons with the following conditions should not be considered for school bus operation for a minimum of one year, with reevaluation every six months for two years, then yearly. Such persons *must* be asymptomatic and have normal resting and submaximal stress ECG's and satisfactory coronary angiography for certification.

1) Myocardial infarction
2) Coronary artery bypass surgery

C. Persons with these conditions should not be permitted to operate a school bus until full recovery is demonstrated and documented.

1) Pulmonary embolism—minimum six months
2) Symptomatic hypertension
3) Congenital heart disease surgically corrected

D. Symptomatic valvular heart disease and congenital heart conditions disqualify for school bus operation. If asymptomatic, they quality if the following standards are met.

1) Normal chest x-ray
2) Normal resting and submaximal stress ECG
3) Estimated as "mild" by clinical exam
4) No significant progression in subsequent annual examinations

E. All symptomatic conduction difficulties disqualify for school bus operation. Second and third degree AV blocks disqualify *per se*. All other conduction system disturbances, if asymptomatic, should be considered individually and the burden of proof should be on the applicant to demonstrate functional competency.

3. Cardiac Drugs

A. Rhythm control drugs. Examples: quinidine, procainamide (Pronestyl®), propranolol (Inderal®). Use of such drugs *disqualifies* the applicant for school bus operation unless the applicant furnishes acceptable evidence that the underlying cardiac condition (diagnosis) is benign with absence of ECG evidence of myocardial injury and with no history of, or reasonable anticipation of, syncope or presyncopal light-headedness associated.

B. Antianginal agents. Examples: nitroglycerin isosorbide (Isordil®), pentaerythritol (Peritrate®), propranolol (Inderal®). Use of such drugs for the treatment of angina *disqualifies* the applicant for school bus operation as "de facto" evidence of "coronary insufficiency" whether or not anginal pain is present.

C. Digitalis glycosides. Examples: digoxin, digitoxin, digitalis leaf. Use of such drugs *disqualifies* the applicant for school bus operation *unless* the certifying physician establishes that the person has "a normal* resting and submaximal stress ECG, no residual cardiac complications and no physical limitations (syncope angina, dyspnea)."[2]

D. Antihypertensive agents. Examples: methyldopa (Aldomet®), thiazides, reserpine. Use of such agents is *not disqualifying*.

E. Systolic pressures repeatedly over 180 and diastolic pressures persistently over 105 are *disqualifying* for school bus operation whether or not the applicant is under treatment.

F. Anticoagulants. Example: warfarin (Coumadin®). The use of such an agent is *not disqualifying* for school bus operation though the underlying disease process for which the drug is being used may be disqualifying.

---

*except for "digitalis effect"

REFERENCES

1. Cardiovascular Problems Associated with Aviation Safety. *Am J Cardiol* (Oct) 1975.
2. US Dept of Transportation: The Regulatory Criteria for Evaluation under Section 391.41 (b) (4), revised 9/76.

PHYSICIANS NOT EXEMPT FROM JURY DUTY

Physicians are no longer automatically exempt from serving as a juror. However, there are some qualifying circumstances under which a physician might be excused in the discretion of a judge for hardship or extreme inconvenience. Physicians interested in further details may contact the SMS Physicians Alliance Division: toll-free 1-800-362-9080.

Problems of a Physician's Widow

Following the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Ave, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

It is important that a widow, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the Wisconsin Pharmacy Examining Board, 1400 E Washington Ave, Madison, Wis 53702.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patient will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A widow should consult her attorney as to whether

the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the widow's share of such assets. Some physicians will have attempted to do this during lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

HAVE YOU BEEN CALLED LATELY?

or, What's the Latest on the Patients Compensation Panels?

In 1975 MANDATORY pretrail screening panels were legislated. See article in June 1978 Blue Book, page 41, "You Are Being Sued for Malpractice, or What the Physician Should Know About Malpractice Litigation," for a description of the panel process. A pamphlet including information on the Patients Compensation Panels is also available from the State Medical Society's Physicians Alliance on request, "So You've Been Sued . . . Now What?"

Do I have to serve as a panel member if I am called?

Yes, by law, unless the administrator of the panels excuses you for "good cause." *Good cause* is interpreted as meaning: (1) a conflict of interest, (2) a schedule conflict, such as operative, emergency, out of the state or country, or a pre-arranged lecture series, etc, (3) strong moral, ethical or religious beliefs, and (4) if the medical issue is one with which the physician is not familiar.

How much of my time will be required?

Physicians are appointed to the Formal Panel (5-members) for a period of six months. Physicians also may be appointed to the Formal Panel, as well as the Informal Panel (3-members) on a case-by-case basis. You will be expected to review the specifics of the case, such as medical records, depositions, etc, before the panel hearing. These records are usually sent two to four weeks prior to the hearing date. The physician panel member also may be asked to alert the panel of other medical experts who should be consulted. The hearing, with all parties present, averages two days. Informal Panels usually take one day, plus the panel deliberation of approximately 3 to 5 hours. Formal Panels are often longer; four days may be required. In Milwaukee, meetings are held evenings or weekends if possible. You may be required to travel to another city for the hearing.

What if I don't want to serve on the panel?

The Panel Administrator (through the Supeme Court of Wisconsin) does have sanction applicable to civil actions (Formal Panels) and could hold a physician in contempt for non-appearance or tax the physician for the costs of the panel hearing. However, both the State Medical Society and the Panel Administrator are interested in maintaining a positive atmosphere in this relatively new approach to resolving professional liability disputes. The Society urges a cooperative attitude. And to date, results are encouraging. As of May 1978, only 5 out of about 105 cases have been filed in court after a panel determination.

What compensation will I receive for my time?

As a panel member, you will be paid $75 per day for attendance at the hearing, plus travel expenses. Panels can call their own expert witnesses, if this is necessary in addition to panel expertise. Expert medical witnesses are paid according to their regular fee-for-service. While the availability of this medical expertise has been viewed by some as a relatively inexpensive "fishing expedition" for attorneys and their clients, sometimes this second medical opinion settles the issue to the patient's and attorney's satisfaction.

Why me?

Who else? If you would like more information, call or write the SMS Physicians Alliance, PO Box 1109, Madison, WI 53701; telephone toll-free: 1-800-362-9080, or 257-6781 for Madison area.

Estimating disabilities in Worker's Compensation cases as provided in the WISCONSIN ADMINISTRATIVE CODE

Publication of this administrative rule, which became effective April 1, 1975, should aid physicians in estimating disability. It should further reduce controversy and hearings so that physicians treating or evaluating injured workers will not be required to testify at hearings, thus materially conserving their time. The rule was established through a joint effort of a Disability Evaluation Committee named by the Wisconsin Orthopedic Society and the Worker's Compensation Division of the State Department of Industry, Labor and Human Relations.

WORKER'S COMPENSATION
Rule Ind 80.32

IND 80.32 Permanent disabilities. Percentages of loss of use for losses of motion as compared with amputations at the involved joints.

(1) The evaluation of permanent disability is at best difficult. The final evaluation is a composite of elements which can be objectively measured and others that cannot. Believing that a guideline for minimum disabilities associated with certain loss of motion or common medical conditions would assist, the Commission sought the advice of an Orthopedic Advisory Committee. On its recommendation the department adopts the schedule of minimum disabilities set out below. In adopting this schedule the department emphasizes that findings of additional disabling elements would result in an estimate higher than the minimum. An example would be where in addition to a described loss of motion, pain and circulatory disturbance further limited the use of an arm or a leg. The removal of a semi lunar cartilage in a knee with less than a good result would call for an estimate higher than 5% loss of use of the leg at the knee. The same principle would apply to laminectomies or spinal fusions.

The minimum also assumes that the member, the back, etc., was previously without disability. Appropriate reduction should be made for any pre-existing disability.

(2) **Amputations,** upper or lower extremities

At functional level .... Equivalent to amputation at midpoint

Stump unsuitable to accommodate prosthesis ..... Equivalent to amputation at next most proximal joint

Stump not functional .. Grade upward

All ranges of joint motion or degrees of ankylosis not listed below are to be interpolated from existing percent of disability listed.

(3) **Hip**

Ankylosis, optimum position, generally 15° to 30° flexion 50%

Mal position ..... Grade upward

To compute disabilites for loss of motion relate % of motion lost to average range

Shortening of leg (no posterior or lateral angulation)

No disability for shortening less than 3/4 inch

3/4 inch 5%
1 inch 7%
1-1/2 inches 14%
2 inches 22%

Greater than 2 inches of shortening results in greater proportionate rating than above

Prosthesis ..... Minimum of 50%

(4) **Knee**

Ankylosis, optimum position, 170° 40%

Remaining range, 180°-135° 25%

Remaining range, 180°-90° 10%

Prosthesis 40%

Removal of patella ... To be based on functional impairment

Semi lunar cartilage removal
Excellent to good result 5%

(5) **Ankle**

Total ankylosis, optimum position 40%

Ankylosis ankle joint .. 30%

Subtalar ankylosis 15%

(6) **Toes**

Ankylosis great toe at proximal joint 50%

All other toes at proximal 40%

Ankylosis great toe at distal joint 15%

All other toes at any interphalangeal joint .. If no deformity, no disability

Mal position ..... On merits

Loss of motion ..... No disability

(7) **Shoulder**

Ankylosis, optimum position, scapula free . . 55%

In mal position . . . . . Grade upward

Limitation of active elevation in flexion and abduction to 45° but otherwise normal 30%

Limitation of active elevation in flexion and abduction to 90° but otherwise normal 20%

Limitation of active elevation in flexion and abduction to 135° but otherwise normal 5%

(8) **Elbow**

Ankylosis, optimum position, 45° angle

With radio-ulnar motion destroyed . . 60%

With radio-ulnar motion intact 45%

Rotational ankylosis in neutral position . . 20%

Any mal position . . Grade upward

Limitation of motion elbow joint, radio-ulnar motion unaffected

Remaining range—180°-135° 35%

Remaining range—135°-90° 20%

Remaining range—180°-90° 10%

Rotation at elbow joint

Neutral to full pronation 10%

Neutral to full supination 15%

(9) **Wrist**

Ankylosis, optimum position 30° dorsi-flexion 30%

Mal position . . . . . Grade upward

(10) **Complete Sensory Loss**

Any digit . . . . . 50% lesser involvement to be graded appropriately—35% for palmar, 15% for dorsal surface

Total median sensory loss to hand 65-75%

Total ulnar sensory loss to hand 25%

Ulnar nerve paralysis

Above elbow, sensory involvement . . . 50% at wrist

Below elbow, motor and sensory involvement . . . . . 45-50% at wrist

Below elbow, motor involvement only . . . 35-45% at wrist

Below elbow, sensory involvement only . . . . . 5-10% at wrist

Median nerve paralysis

Above elbow, motor and sensory involvement . . . . . 55-65% at wrist

Thenar paralysis with sensory loss . . . 40-50% at wrist

Radial nerve paralysis

Complete loss of extension, elbow wrist and fingers . . . 45-55% at shoulder

Complete loss of extension, wrist and fingers . . . . . 45-55% at wrist

Pareneal nerve paralysis

At level below knee . 25-30% at knee

(11) **Back**

Laminectomy, no undue symptomatic complaints or any objective findings 5%

Spinal fusion L5-S1, good results 10%

Spinal fusion L4-S1, good results 10%

Cervical fusion, successful 5%

Compression fractures of vertebrae of such degree to cause permanent disability may be rated 5% and graded upward 5%

(12) **Fingers**

(a) Complete ankylosis

Thumb	Mid-position	Extension
Distal joint only	25%	35%
Proximal joint only .	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%

Fingers		
Distal joint only	25%	35%
Middle joint only ..	75%	85%
Proximal joint only .	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints ...	100%	100%

(b) Loss of Motion

Fingers	Loss of Flexion	Loss of Use	Loss of Extension	Loss of Use
Distal joint only	10%	1%	10%	2%
	20%	2%	20%	4%
	30%	3%	30%	6%
	40%	5%	40%	8%
	50%	10%	50%	15%
	60%	15%	60%	20%
	70%	20%	70%	30%
	80%	25%	80%	40%
			100%	60%
Middle joint only ..	10%	5%	10%	2-1/2%
	20%	10%	20%	5%
	30%	15%	30%	10%
	40%	25%	40%	15%
	50%	40%	50%	30%
	60%	50%	60%	50%
	70%	60%	70%	70%
	80%	70%	80%	90%
			100%	100%
Proximal joint only .	10%	5%	10%	2-1/2%
	20%	10%	20%	5%
	30%	15%	30%	15%
	40%	20%	40%	20%
	50%	25%	50%	25%
	60%	30%	60%	40%
	70%	35%	70%	75%
	80%	40%	80%	85%
			90%	100%

■

THE WISCONSIN POISON CONTROL PROGRAM NETWORK . . . .

. . . is approved and coordinated by the Division of Health, Wisconsin Department of Health and Social Services. It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week. Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report regularly to the Division of Health.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/931-4114

Poison Center — Madison Area
University Hospitals
600 Highland Avenue
Madison, WI 53792
Tel 608/262-3702

The three satellite centers are:

Eau Claire Poison Center
Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

Green Bay Poison Center
St Vincent Hospital
P O Box 1221
Green Bay, WI 54305
Tel 414/432-8621

LaCrosse Poison Center
St Francis Hospital
709 South 10th Street
LaCrosse, WI 54601
Tel 608/784-3971

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the
WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES
DIVISION OF HEALTH
PO Box 309 Madison, Wis 53701

Anatomical gifts—the uniform law

WISCONSIN, along with some 40 other states, has adopted the Uniform Anatomical Gift Act, a law under which a donor may leave all or any part of his body for research or transplantation. With the continuing publicity given to transplant technology you can anticipate an increasing number of inquiries on the Uniform Anatomical Gift Act and how your patients can make anatomical gifts. Some typical questions you will face and their answers are:

1. May I leave my body to medical sciences?

Yes. The Uniform Anatomical Gift Act permits you to make this disposition of your body after your death if you are over 18 and of sound mind.

2. Is there a need for such gifts?

Certainly. The need is two-fold, medical research and transplant materials. The training of physicians and research into the cause and cure of human ills requires hundreds of bodies each year. New techniques in transplantation make nearly every person a vital source of needed replacement parts for others.

3. Must I give my entire body?

No. You may decide whether to give your entire body, parts of it and what parts. Because of illness or donor condition, needs at the time of donor's death and the state of technology certain parts may not be usable if donated. It is suggested that the best gift is of the entire body so the needs at the time of its use can dictate how it can best advance health care.

4. Is there any pay to me or my estate for an anatomical gift?

No.

5. How do I make an anatomical gift?

It may be made by your Will or by a separate document. Since a Will may remain unread for some period after an individual's death, it is best that a separate document be used even if a gift is contained in the Will. A sample wallet card, fully legal under the Uniform Act, is printed at left. It must be signed by the donor and two witnesses. It need not be delivered to a doctor, hospital or medical school to be effective.

6. Can I revoke or change the gift?

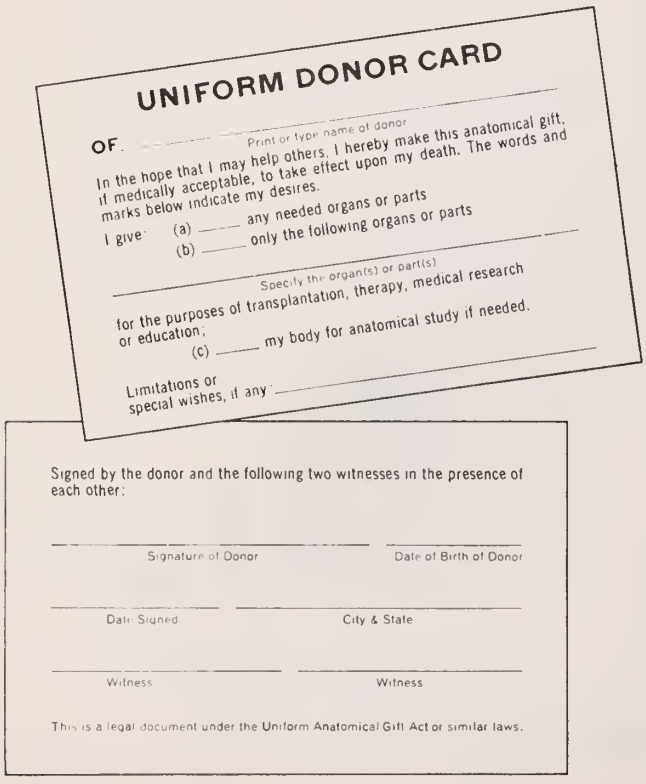
Yes. If the gift is by Will, you may change your Will. If it is by separate document, you may destroy it and sign a new one (or sign none). If the document has been delivered to a doctor or other donee, a document (delivered or not) revoking or changing the gift or an oral statement with witnesses can accomplish this.

7. Does anyone else have a say in this?

Yes. A body may be donated by a decedent's relatives if the deceased has made no objection to this while alive. The parents of a minor donor or the surviving spouse of any donor may revoke the gift. The body must be made available for last rites if the family requests this.

8. If I am killed accidentally, or die away from home, how will people know of the gift?

If you decide to make an anatomical gift you should carry an executed wallet card like the sample with you at all times. Also, the State of Wisconsin recently passed a law permitting anatomical gift donors to put an indication of the gift on their drivers' licenses. Decals which may be affixed to the license are now available (see below).



UNIFORM DONOR CARD

OF _____ Print or type name of donor

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give: (a) ____ any needed organs or parts
(b) ____ only the following organs or parts

_____ Specify the organ(s) or part(s)

for the purposes of transplantation, therapy, medical research or education;
(c) ____ my body for anatomical study if needed.

Limitations or special wishes, if any _____

Signed by the donor and the following two witnesses in the presence of each other:

Signature of Donor — Date of Birth of Donor

Date Signed — City & State

Witness — Witness

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

Further information relating to donation of bodies for medical research purposes can be obtained from the Department of Anatomy, University of Wisconsin Center for Health Sciences, 600 Highland Ave, Madison, Wis 53792; or from the Department of Anatomy, The Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wis 53226.

Uniform Organ Donor Cards and Decals are available from the Kidney Foundation of Wisconsin, Inc, PO Box 350, Madison, Wis 53701; phone 608/241-1279.

Regarding the donating of eyes, inquiries may be directed to the Milwaukee Eye Bank, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. ■

"LIVING WILL" ON USE OF MEASURES TO SUSTAIN LIFE

Many people express their desire that no "heroic" measures be used to sustain their physical functions if this would result in their being totally incapacitated, comatose, or otherwise severely impaired. Various forms of a "living will", purporting to direct the scope of care to be given or withheld in such situations have been prepared and are in circulation.

It is unlikely that any of these documents can adequately address the complex medical judgments in a particular case but they do offer some guidance on the attitude of a patient who may no longer be able to speak for himself. It remains for serious and considered ethical and professional evaluation to see how and if the expressed attitude can be reflected in the management of the patient.

THE OPTOMETRIST REFERRAL LAW

In 1977 the Wisconsin Legislature enacted a law permitting optometrists in Wisconsin to use some topical drugs. The law, Chapter 280, Laws of 1977, includes a **mandatory** referral section—the first of its kind in this state. It is reprinted below since some physicians undoubtedly will be receiving referrals in the near future.

449.19 Referral to other medical specialists

If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate medical specialist for further evaluation.

CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701; or tel. 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

MEDIC ALERT
FOUNDATION INTERNATIONAL

The Medic Alert emblem is designed to alert emergency personnel to hidden medical conditions. On the back of the emblem is the member's hidden medical condition along with an ID number and 24-hour emergency telephone number which can be utilized to retrieve the computerized emergency medical data within seconds.

Information that is stored can include physician's telephone number, type of insurance policy, next-of-kin, blood type, medication name and dosage.

The Medic Alert Foundation estimated that one out of five Americans has a hidden medical condition, ranging from serious medication allergies to heart problems and diabetes.

In a recent twelve-month period, the service which is subscribed to by over 1.3 million people was directly credited with saving over 2,000 lives.

Free information can be obtained from Medic Alert, Turlock, California 95380. ■

1978-79 REGISTRY OF PHYSICIANS, PHYSICAL THERAPISTS, PODIATRISTS, AND PHYSICIAN'S ASSISTANTS

This registry is available from the Wisconsin Medical Examining Board, 1400 East Washington Ave, Madison, Wis 53702, at a cost per copy of $3.12. Checks should be made payable to the Wisconsin Medical Examining Board. Physicians no longer receive a complimentary copy due to a recent change in the Statutes requiring that the Board now charge for this registry. ■

Arthritis Foundation of Wisconsin

The Arthritis Foundation of Wisconsin sponsors a comprehensive program of research, patient information and services, professional training and public education. The Foundation operates a telephone Arthritis Information and Referral Resource to help arthritis sufferers, their families and health professionals with their questions on the care and treatment of arthritis. The toll-free number is 1-800-242-9945; metro Milwaukee call 276-0490. Information about arthritis and the services available to arthritis sufferers in Wisconsin also can be obtained by writing Arthritis Foundation of Wisconsin, Fenwick Building, 1442 North Farwell Ave, Milwaukee, Wis 53202. ■

NARCOTICS

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The initial registration application may be obtained from the Chicago Regional Office. The Regional Office of DEA in Chicago has informed the State Medical Society that DEA Headquarters will then annually mail a renewal application to each physician once initially registered.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P O Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

Adoption

STATE LAW REGULATES the adoption of children and licenses the agencies involved in adoptive placements to the problems and abuses inherent in "black market" adoptions.

Licensed private child welfare agencies and special governmental agencies are authorized to take custody of children, become their guardians, provide care and maintenance for them, place them in foster homes (which must also be licensed) and initiate necessary steps leading to adoption.

No one else may perform these functions in the adoptive process and the physician must be careful to refer patients either having a child for adoption or seeking to adopt to the appropriate agencies. (See box on this page.)

Placement of a child for adoption or receipt of such a placement may subject those involved, including an intermediary, to criminal prosecution. Failure of the parties to follow legally established procedures for adoption is grounds for a court to refuse to grant the adoption.

Similar precautions are taken with interstate adoption situations and consent must be obtained from the Department of Health and Social Services before any child is brought into Wisconsin or sent from this state for adoption. ■

GOOD SAMARITAN LAW

The Legislature has broadened the immunity provided by the Wisconsin Good Samaritan Law to cover any person rendering aid at the scene of an emergency. First enacted to protect physicians, these laws are common throughout the United States. They are designed to encourage prompt care for persons who are injured or become ill away from normal locations where treatment is given.

The scene of an emergency does not include a hospital or physician's office. Persons employed and trained to render emergency care, acting for compensation and within the scope of their employment are not protected under the law.

ABORTION

Following the pattern of several other states, Wisconsin adopted a law in 1978 denying public subsidies for nontherapeutic abortions except in the case of conception due to sexual assault or incest. This law covers subsidies from all public sources in the State.

The law also grants immunity to physicians and hospitals from civil liability for refusal to perform an abortion. In the case of a physician this immunity is given if the refusal is based on religious or moral precepts.

REFER CHILD ADOPTION CASES TO THESE LICENSED AND PUBLIC AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc. 6800 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson Street, Milwaukee 53202.

Catholic Social Services, 207 East Michigan Street, Milwaukee 53202.

Catholic Charities, Inc., 128 South Sixth Street, Box 266, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Catholic Social Services, 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Boulevard, Milwaukee 53208.

Seven Sorrows of Our Sorrowful Mother Infants' Home Necedah 54646.

World Family Ltd, 4906 West Fond du Lac Ave, Milwaukee 53216

The Human Element, Inc, 2701 N 56th St, Milwaukee 53201

PUBLIC AGENCIES:

*Division of Economic Assistance (See page 87 for list of Regional Offices).

*Milwaukee County Department of Social Services, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

* Nondenominational.

MATERNITY HOMES

Lutheran Maternity Home, 1910 South Avenue, La Crosse 54601.

Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Manor, 19305 West North Ave., Brookfield 53005.

St Francis Maternity Residence, 709 S Tenth St, La Crosse, 54601.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Until recently, only licensed physicians or registered pharmacists could lawfully offer to sell or sell contraceptive articles.

Under an opinion of the Attorney General, dated May 16, 1977, interpreting Section 450.11(5), enacted in 1976, professional nurses registered under Section 441.06, Wis. Statutes, 1975, may offer to sell or sell any contraceptive article, including an oral contraceptive drug, provided the latter has been prescribed by a physician and that the article offered for sale or sold has been prepared for delivery. Such drugs include birth control pills.

Except for sales to physicians and surgeons licensed under Sec. 448.06(1), Wis. Stats., no person may exhibit, display, advertise, offer for sale, or sell any drug, medicine, mixture, preparation, instrument, article or device of any nature used or intended or represented to be used to produce a miscarriage.

Any violation of the above statutes subjects the violator to a fine of One Hundred to Five Hundred Dollars, or imprisonment not to exceed six months, or both.

References: Section 450.11, Wisconsin Statutes, 1975, and Opinion of the Attorney General, May 16, 1977.

Inquiries concerning national advertising copy should be directed to:

STATE MEDICAL JOURNAL ADVERTISING BUREAU, 711 South Blvd, Oak Park, Ill. 60302; or local (Wisconsin only) advertising copy to: WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin 53701.

The *Wisconsin Medical Journal* is one of 40 state medical journals published monthly in the United States. These journals represent 47 state medical societies. Each is an official publication of the state society it represents, and is owned and operated by it.

The *Wisconsin Medical Journal* has a circulation of more than 5,000. About 80 percent of the physicians in Wisconsin receive the Journal as part of their Society membership dues. Others who receive the Journal, either complimentary or through paid subscriptions, include senior medical school students at the University of Wisconsin and Medical College of Wisconsin, hospital administrators, faculty members of the two medical schools, medical clinic managers, most major medical school libraries in the United States and abroad, prominent physicians in the United States, health-related government agencies, and other health organizations in Wisconsin and the United States.

Rule on prescribing, dispensing of amphetamines

EFFECTIVE NOVEMBER 1, 1977 virtually all sales and prescriptions of amphetamines were banned in Wisconsin in an action taken by the State Medical Examining Board. This action is found in Chapter Med 10.02(2) (s) of the Wisconsin Administrative Code. It includes only certain Schedule II controlled substances. The rule reads as follows:

UNPROFESSIONAL CONDUCT DEFINED

Med. 10.02(2) (s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch. 161 Wis. Stats. to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

(INFORMATIONAL NOTE: The following list, although not exhaustive or exclusive, does include most of the brand-name drugs available in the United States as of March 1, 1978, which fall within the definition of ch. 10.02(2)(s): Benzedrine, Biphetamine, Delcobese, Desoxyn, Dexamyl, Dexedrine, Eskatrol, Fetamin, Obetrol, Obotan, and Preludin).

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owdered Soyalac mixed with water (according to ctions on the label) is an inexpensive, soy-based nt formula your patients can buy.

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Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13; Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ■

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

CONSTITUTION AND BYLAWS TO BE REVISED

At the 1979 Annual Meeting of the State Medical Society the Council and House of Delegates directed that the Constitution and Bylaws be revised. There were no amendments in 1979, but they are being reprinted on the following pages for the benefit of members in their deliberation of the revision.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to bring into one compact organization the entire medical profession of the state of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members, and in March 1976 to add the president-elect and vice-speaker. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for

*COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through April 1978.

which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from eight districts, and a speaker and vice-speaker of the House of Delegates.

Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the approval and confirmation of the House of Delegates.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph; second paragraph amended in March 1973. Number of districts reduced from thirteen to eight in April 1975.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the eight districts, except that in any councilor district embracing a membership of 200 or more, there shall be elected one additional councilor for each additional 200 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965. Number of members used as basis for councilor representation changed from 250 to 200 in April 1975.

As nearly as possible, one-third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

SEC. 4. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician, who holds a license to practice medicine and surgery, and whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such

membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election. Such resident members shall have the right to vote and hold office.

Sec. 5. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice. Except as otherwise provided in Section 14 of this Chapter, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

Sec. 6. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

Sec. 7. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

Sec. 8. *Honorary Membership.* Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

Sec. 9. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

Sec. 10. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, or who practices less than six (6) weeks per year, is eligible for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

Sec. 11. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

Sec. 12. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

Sec. 13. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the *Wisconsin Medical Journal,* and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

Sec. 14. *Nonresident Membership.* Any member who moves

to the jurisdictional area of another constituent association, while in dues-paid status, may be granted nonresident membership upon written request to and approval by the Council. A nonresident member shall have all the rights and privileges of regular membership except the rights to vote and hold office. This nonresident category shall require no involvement of a county medical society. Neither the time limit in paragraph 2, Section 5 of this Chapter nor the provisions of Chapter VIII shall apply to this Section. The annual dues shall be established by the Council.

SEC. 15. *Senior Membership.* Any member who has reached age 65 and practices 1,000 hours or less during a calendar year, but does not qualify for associate membership, may upon application, recommendation by the county medical society, and approval by the State Medical Society, be granted senior membership upon payment of 50% of regular member dues. Such change shall be effective January 1 following receipt of such request.

COMMENT: Section 13, added in May 1964; sections 14 and 15, in April 1978.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

COMMENT: Section 2 on publication of scientific papers rescinded in May 1972.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966; second paragraph of Section 2, below, amended in March 1973.

The term "full-paid members" as used in this section includes regular members of the Society, life members, affiliate members, associate members, educational members, resident members, honorary members, special service members, and members whose dues are waived or remitted by official action of the Society. Members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provision.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate for each district, except that in any councilor district embracing a membership of 500 or more, there shall be elected one additional delegate for each additional 500 members or major fraction thereof, and one delegate representing all of the specialty sections. This newly elected committee shall become operative at the close of the final meeting of that annual session, and shall function until the close of the final meeting of the following year's annual session. The incoming committee shall meet with the existing committee, but without vote, during the overlapping days of the annual session. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each

of the offices to be filled at the next annual session. No two candidates for president-elect shall be from the same district.

The Committee on Nominations shall convene at least two months prior to the annual session of the House of Delegates to prepare a slate of candidates. This meeting, to be held at the Society headquarters, shall include an open session of not less than one hour to allow individual nomination of candidates. Any vacancy occurring in the Committee on Nominations between the date of its election and the time of its reporting shall be filled by appointment by the councilor or councilors of the councilor district in which the vacancy occurs; provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot of the several section chairmen.

COMMENT: Section 1 amended in March 1973; first sentence of paragraph one further amended in April 1975; section further amended in March 1976.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. The House of Delegates shall elect the president-elect, speaker and vice-speaker of the House of Delegates, and delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the legal votes cast shall be necessary to elect. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie for the lowest number of votes and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of *Wisconsin Medical Journal).*

In March 1973 the House reaffirmed the above and stated that as general manager, the secretary is in charge of all Society divisions, activities, and personnel.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and

other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the *Journal* and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice-chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMISSIONS AND COMMITTEES

SECTION 1. The Council shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary properly to conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers who are eligible for membership cannot be appointed or elected. Persons not eligible for membership in the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such committees or commissions. Such individuals shall not have a vote or the right to hold office.

Each commission and committee shall have the duty of keeping currently informed on matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities for improvement; of determining the best solutions it can to the specific matters referred to it; of contributing in its area to the achievements of the Society and its members in the protection and improvement of the quality of life for the whole human family; and finally, of making all its efforts useful by passing on to the Society's Council or House of Delegates in the most effective manner possible the results of its studies and activities with appropriate recommendations for action. In addition, each commission or committee shall represent the Society's interests by continuing contacts with voluntary and governmental agencies having related concerns with a view to coordinated efforts serving the best health interests of the people of Wisconsin.

SEC. 2. Specialty sections. The specialty sections shall be regarded as special committees of the Society to which the Council or any commission or committee may turn for advice and

assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of the talents available through these sections and their related specialty societies.

COMMENT: This Chapter repealed and re-created in April 1975; amended in 1978 as to membership.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall be deemed delinquent until his name is properly reported and his dues for the current year are properly remitted. The name of any member who has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before October 15 shall be removed from the active membership rolls of his county society and this Society until his name is properly reported and all his dues for the year of enrollment are properly paid.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure.

CHAPTER XI

COUNTY SOCIETIES

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 5. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 6. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 6, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC. 7. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 8. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SPECIALTY SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such specialty sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

SEC. 7. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VII of these Bylaws.

COMMENT: Section 7 added in April 1975.

CHAPTER XIII

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed. ■

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. The should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

Adopted June 7, 1957 ■

Life is short . . . Art is long . . . Experience is difficult

Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was created in 1955 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Its initial fund was used for student loans, but the Foundation's scope of interest has grown with the increased volume of financial contributions to worthy projects.

STUDENT LOANS. Since its inception, the Student Loan Program has helped students prepare for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Funds for those loans have been given to the Foundation to administer according to the wishes of the donors.

CHARITABLE ASSISTANCE. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

MEDICAL STUDENT EXTERNSHIP PROGRAM. This is a newer Foundation project which has been highly successful. It provides an eight-week externship with a family physician for students who have completed their freshman year of medical school. Participating students receive fellowship grants from the Foundation.

RESEARCH ACTIVITY. Research projects on a variety of topics have been done with Foundation support. The Foundation is available to assist in planning, administering, and funding investigations of a scientific or medical socio-economic nature.

CONTINUING MEDICAL EDUCATION. Educational activity, in the form of postgraduate teaching programs, is a major thrust of the Foundation. Among these programs are a Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on such subjects as medical aspects of mental retardation, prematurity, the newborn, stroke, and athletic injuries as well as many other medical subjects.

Since 1975, the accreditation of continuing medical education programming of Wisconsin hospital and specialty groups has been implemented through the Foundation.

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted. restricted, or earmarked for specific purposes of interest to the donor.

In addition, service can be provided to those who wish to establish a Living Trust by naming the Foundation as trustee. Use of this mechanism can result in an immediate tax advantage for the donor while providing a guaranteed income for life. The principal would revert to the Foundation upon death of the donor.

ALL TYPES OF CONTRIBUTIONS TO THIS FOUNDATION ARE TAX-DEDUCTIBLE.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE AESCULAPIAN SOCIETY of the State Medical Society's CES Foundation is seeking more members for support of its projects in this interesting and rewarding field. Recently two other Foundation groups involved in medical history were combined with the Aesculapian Society—the Permanent Commission to the Museum of Medical Progress and the Academy of Medical History—to make a stronger organization. The Society is now charged with the promotion and operation of the Museum of Medical Progress at Prairie du Chien as well as the preservation of Wisconsin's medical history. Although medical families comprise a large percentage of the membership, anyone who is interested in the group's objectives is eligible to belong. A newsletter is published quarterly to keep the membership aware of ongoing activities and a general membership meeting is held annually at the time of the Annual Meeting of the State Medical Society.

The Aesculapian Society has more than 900 members; it welcomes many more. The annual donation is $10 for regular or $25 for sustaining membership. Make your check payable to the CES Foundation—Aesculapian Society, and mail to Box 1109, Madison, Wis 53701.

COUNCILOR DISTRICTS AND COUNCILORS

District	Councilor
1	John P Mullooly, MD, Milwaukee
	Paul G LaBissoniere, MD, Wauwatosa
	Carl S L Eisenberg, MD, Milwaukee
	Elizabeth A Steffen, MD, Racine
	Wayne J Boulanger, MD, Milwaukee
	Daniel K Schmidt, MD, Milwaukee
	John J Foley, MD, Menomonee Falls
	William A Nielsen, MD, West Bend
	Irwin J Bruhn, MD, Walworth
2	J D Kabler, MD, Madison
	Gerald C Kempthorne, MD, Spring Green
	William P Crowley, MD, Madison
	Allen O Tuftee, MD, Beloit
	Cyril M Hetsko, MD, Madison
3	Pauline Jackson, MD, LaCrosse
4	John J Kief, MD, Rhinelander
	Jung K Park, MD, Wisconsin Rapids
5	John U Peters, MD, Fond du Lac
	Timothy T Flaherty, MD, Neenah
6	Antoine Barrette, MD, Peshtigo
	Irvin L Schroeder, MD, Plymouth
7	Paul S Haskins, MD, River Falls
8	Joseph M Jauquet, MD, Ashland

THE SOCIETY'S PLACEMENT SERVICE AIDS PHYSICIANS AND COMMUNITIES

One of the many functions of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal*. This is a classified advertising section which is available to members of the State Medical Society, other physicians, communities, clinics, hospitals and others at reasonable rates.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, tel. 608/257-6781; and/or *Wisconsin Medical Journal*, Box 1109, Madison, Wis. 53701

Officers and Councilors 1979-1980

State Medical Society of Wisconsin

330 East Lakeside St (PO Box 1109), Madison, Wis 53701 • Tel 608/257-6781

Toll-free in Wisconsin: 1-800-362-9080

OFFICERS OF THE SOCIETY

PRESIDENT (1979-1980)
Darold A Treffert, MD, 459 E First St, Fond du Lac 54935

PRESIDENT-ELECT (1979-1980)
Russell F Lewis, MD, 1000 North Oak Ave, Marshfield 54449

SECRETARY/GENERAL MANAGER
Earl R Thayer, 330 East Lakeside St, Madison 53701

TREASURER (1979-1980)
Richard W Edwards, MD, 1313 W Seminary St, Richland Center 53581

SPEAKER (1979-1981)
Albert J Motzel Jr, MD, 1111 Delafield St, Waukesha 53186

VICE-SPEAKER (1979-1980)
Duane W Taebel, MD, 1836 South Ave, LaCrosse 54601

PAST PRESIDENT (1978-1979)
Jules D Levin, MD, 1530 Spruce Court, Milwaukee 53217

THE COUNCIL

CHAIRMAN
Paul S Haskins, MD, River Falls

VICE-CHAIRMAN
Timothy T Flaherty, MD, Neenah

COUNCILORS (by districts*)

FIRST: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha Counties

John P Mullooly, MD (1979-1982)
8430 W Capitol Dr, Milwaukee 53222

Paul G LaBissoniere, MD (1979-1982)
10425 W North St, Wauwatosa 53226

Wayne J Boulanger, MD (1978-1981)
324 E Wisconsin Ave, Milwaukee 53202

Daniel K Schmidt, MD (1978-1981)
720 E Wisconsin Ave, Milwaukee 53202

John J Foley, MD (1978-1981)
PO Box 427, Menomonee Falls 53051

William A Nielsen, MD (1978-1981)
PO Box 178, West Bend 53095

Irwin J Bruhn, MD (1978-1981)
Walworth 53184

Carl S L Eisenberg, MD (1977-1980)
3003 West Good Hope Rd
Milwaukee 53209

Elizabeth A Steffen, MD (1978-1981)
734 Lake Ave, Racine 53403

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk Counties

J D Kabler, MD (1979-1982)
1552 University Ave, Madison 53706

Cyril M Hetsko, MD (1979-1982)
1313 Fish Hatchery Rd, Madison 53715

Gerald C Kempthorne, MD (1979-1982)
PO Box 466, Spring Green 53588

William P Crowley, MD (1978-1981)
20 S Park St, Madison 53715

Allen O Tuftee, MD (1979-1982)
1905 Huebbe Parkway, Beloit 53511

THIRD: Buffalo, Crawford, Jackson, Juneau, LaCrosse, Monroe, Trempealeau, Vernon Counties

**Pauline Jackson, MD* (1977-1980)
1836 South Ave, LaCrosse 54601

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

John J Kief, MD (1977-1980)
1020 Kabel Ave, Rhinelander 54501

**Jung K Park, MD* (1977-1980)
410 Dewey St, Wisconsin Rapids 54494

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

John U Peters, MD (1979-1982)
505 E Division, Fond du Lac 54935

Timothy T Flaherty, MD (1977-1980)
547 E Wisconsin Ave, Neenah 54956

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Antoine Barrette, MD (1977-1980)
132 N Emery Ave, Peshtigo 54157

Irvin L Schroeder, MD (1979-1982)
210 Selma St, Plymouth 53073

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, Washburn Counties

Paul S Haskins, MD (1977-1980)
409 Spruce St, River Falls 54022

EIGHTH: Ashland, Bayfield, Douglas, Iron, Sawyer Counties

Joseph M Jauquet, MD (1978-1981)
200 7th Ave West, Ashland 54806

Past President *Levin*
President *Treffert*
Speaker *Motzel*
President-elect *Lewis*
Vice-speaker *Taebel*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

CALENDAR YEARS 1979-1980

Delore Williams, MD, 8501 W Lincoln Ave, West Allis 53227

Patricia J Stuff, MD, PO Box 522, Bonduel 54107

John K Scott, MD, 1605 Monroe St, Madison 53711

CALENDAR YEARS 1980-1981

Gerald J Derus, MD, 5001 Monona Dr, Madison 53716

Henry F Twelmeyer, MD, 2500 N Mayfair Rd, Wauwatosa 53226

ALTERNATE DELEGATES TO THE AMA

CALENDAR YEARS 1979-1980

John D Riesch, MD, PO Box 427, Menomonee Falls 53051

Cornelius A Natoli, MD, 2760 Hagen Rd, LaCrosse 54601

Richard W Edwards, MD, 1313 W Seminary St, Richland Center 53581

CALENDAR YEARS 1980-1981

Warren H Williamson, MD, 500 Walton, Racine 53402

John R McKenzie Jr, MD, 415 S Meadow, Oshkosh 54901 ■

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*Map indicating location of districts, opposite page.

Note: Officers, councilors, delegates, and members of Commissions and Committees are elected at the Annual Meeting (May 1979). Dates in parentheses indicate beginning and expiration of term of office.

AMA Delegates and Alternates' terms of office are on a calendar basis, although elected at the Annual Meeting.

* Doctors Jackson and Park appointed in 1979 to fill unexpired terms of Doctors Natoli and Lewis, respectively.

Officers and Councilors: 1979-1980

STATE MEDICAL SOCIETY OF WISCONSIN

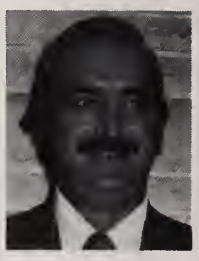
D A Treffert, MD
President

J D Levin, MD
Past President

P S Haskins, MD
Council Chairmon
Councilor, Dist 7

R F Lewis, MD
President-elect

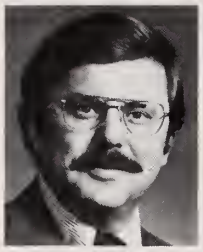
A J Motzel, Jr, MD
Speaker



R W Edwords, MD
Treasurer

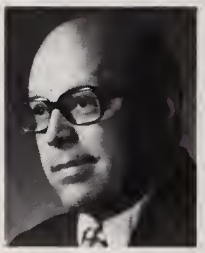
E R Thayer
Secretary

D W Taebel, MD
Vice-Speaker

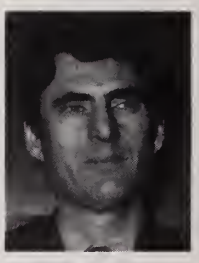


T T Flaherty, MD
Council V-Choirmon
Councilor, Dist 5

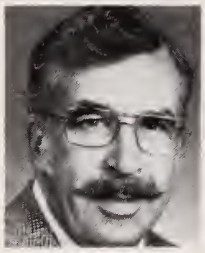
W J Boulanger, MD
Councilor, Dist 1



I J Bruhn, MD
Councilor, Dist 1



J J Foley, MD
Councilor, Dist 1



P J LaBissonlere, MD
Councilor, Dist 1

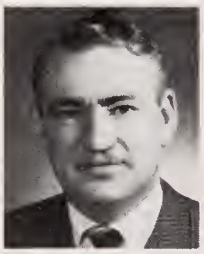
J P Mullooly, MD
Councilor, Dist 1

W A Nielsen, MD
Councilor, Dist 1

D K Schmidt, MD
Councilor, Dist 1

C S L Eisenberg, MD
Councilor, Dist 1

E A Steffen, MD
Councilor, Dist 1



W P Crowley, MD
Councilor, Dist 2

A O Tuftee, MD
Councilor, Dist 2

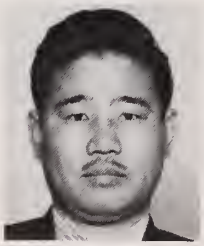
C M Hetsko, MD
Councilor Dist 2

J D Kabler, MD
Councilor, Dist 2

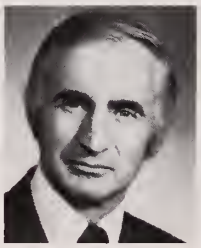
G C Kempthorne, MD
Councilor, Dist 2

P M Jockson, MD
Councilor, Dist 3

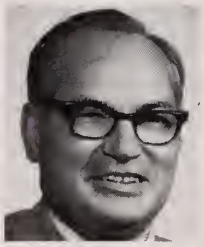
J J Kief, MD
Councilor, Dist 4



J K Park, MD
Councilor, Dist 4

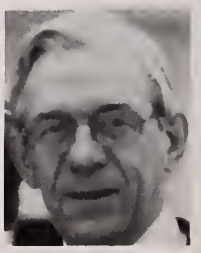


J U Peters, MD
Councilor, Dist 5



Antoine Borrette, MD
Councilor, Dist 6

I L Schroeder, MD
Councilor, Dist 6



J M Jouquet, MD
Councilor, Dist 8

Commissions and Committees—1979-1980

State Medical Society of Wisconsin

330 East Lakeside St (Box 1109), Madison Wis 53701 • Tel 608/257-6781

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COMMISSIONS

COMMISSION ON PUBLIC INFORMATION

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations, and recruit and retain physician members of the Society and encourage their active participation in the affairs of the county and state societies and the American Medical Association.

Joseph W Edgett, Jr, MD, LaCrosse, 1980

Mark J Popp, MD, Brookfield, 1980

Vacancy, 1980

Richard W Shropshire, MD, Madison, 1981

Wallace MacMullen, MD, Green Bay, 1981

Richard A Henry, MD, Chippewa Falls, 1981

Herbert F Sandmire, MD, Green Bay, 1982

Charles Sorensen, MD, Wisconsin Rapids, 1982

S J Graiewski, MD, Oshkosh, 1982

WISCONSIN MEDICAL JOURNAL

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

EDITORIAL BOARD

Victor S Falk, MD, Edgerton, 1980
Chairman and Medical Editor
Harlan M Levin, MD, Janesville, 1980
Melvin F Huth, MD, Baraboo, 1980
Richard D Sautter, MD, Marshfield, 1981
M C F Lindert, MD, Milwaukee, 1981
Wayne J Boulanger, MD, Milwaukee, 1982
Harold H Scudamore, MD, Monroe, 1982
Garrett A Cooper, MD, Madison, Emeritus

EDITORIAL ASSOCIATES (appointed annually by Council)

Wayne J Boulanger, MD, Milwaukee
Chairman and Editorial Director
John P Mullooly, MD, Milwaukee
T H McDonell, MD, Waukesha
Philip J Dougherty, MD, Menomonee Falls
Raymond A McCormick, MD, Green Bay
Brenton H Field, Jr, MD, Milwaukee

Chairman and vice-chairman of commissions and committees are elected at the first meeting following the Annual Meeting. The BLUE BOOK is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

COMMISSION ON MEDIATION AND PEER REVIEW (formerly Commission on Mediation and Professional Ethics and Commission on Peer Review)

This commission may have up to 25 members. It shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, professional ethics, and fees. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, fees, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Council. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Charles E Koepp, MD, Marinette, 1980
Herman J Dick, MD, Sheboygan, 1980
Harry F Weisberg, MD, Milwaukee, 1980
Rocco Latorraca, MD, Cudahy, 1980
Robert E Johnston, MD, Green Bay, 1980
Richard Logan, MD, Madison, 1980
Melvin F Huth, MD, Baraboo, 1980
Mark Lochner, MD, Waupaca, 1980
William D James, MD, Dousman, 1980
David Westgard, MD, LaCrosse, 1980
Gerald C Kempthorne, MD, Spring Green, 1981
G John Weir, Jr, MD, Marshfield, 1981
Brian T Coffey, MD, Racine, 1981
John B McAndrew, MD, Oshkosh, 1981
Lloyd R Cotts, MD, Rice Lake, 1981
John Flannery, Jr, MD, Wausau, 1981
Joseph B Grace, MD, Green Bay, 1981
James M Huffer, MD, Madison, 1981
Thomas Jennings, MD, West Allis, 1981
John D Riesch, MD, Menomonee Falls, 1981
Michael McCormick, MD, Waukesha, 1982
Ronald J Darling, MD, Waukesha, 1982
Richard W Edwards, MD, Richland Center, 1982
Leo Grinney, MD, Racine, 1982
Charles Mann, MD, Madison, 1982
John A DeGiovanni, MD, Prairie du Sac, 1982

COMMISSION ON CONTINUING MEDICAL EDUCATION

This commission shall consist of nine appointed members and the deans of the two medical schools in Wisconsin, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commissions on Peer Review and Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the annual meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

Martin Z Fruchtman, MD, Waukesha, 1980

Joseph C Darin, MD, Milwaukee, 1980

George A Berglund, MD, Milwaukee, 1980

John L Raschbacher, MD, Waukesha, 1981

Leonard H Wurman, MD, Wausau, 1981

James T Houlihan, MD, Woodruff, 1981

Edwin L Overholt, MD, LaCrosse, 1982

Bradley G Garber, MD, Osseo, 1982

Paul B McAvoy, MD, Neenah, 1982

COMMISSION ON GOVERNMENTAL AFFAIRS

This commission shall concern itself with all state and federal health legislation, its analysis and communication to the membership; preparing and securing state or federal health legislation for the best interests of the public, scientific medicine, and the medical profession; legislative representation and liaison, state and federal; informing the membership of the Society of important proposed legislation and encouraging members to be active individually in political affairs; liaison between the Society and executive and legislative branches of government; coordination of county legislative committees required by the Bylaws.

Membership of the Commission on Governmental Affairs shall include a representative from each of the specialty sections of the Society. These representatives shall be appointed by the specialty sections annually. Such appointments shall be subject to the approval by the Council. Representatives on the Commission from the specialty sections need not be counted for purposes of a quorum for a meeting of the Commission on Governmental Affairs, but shall have the right to vote.

Robert F Purtell, Jr, MD, Milwaukee, 1980

Jack D Edson, MD, Eau Claire, 1980

Raymond C Zastrow, MD, Wauwatosa, 1980

Joseph M Lubitz, MD, Oconomowoc, 1981

Martin L Janssen, MD, Friendship, 1981

Ralph L Suechting, MD, Neenah, 1981

Thomas P Belson, MD, Waukesha, 1982

Theodore C Fox, MD, Antigo, 1982

J D Kabler, MD, Madison, 1982

The Commission also has a voting representative from each of the specialty sections of the Society, and several subcommittees appointed by the Commission chairman.

PHYSICIANS ALLIANCE COMMISSION

This commission shall have 18 members consisting of one for each Councilor District, except that District 2 shall have two members and District 1 shall have seven members. In addition, the President of the State Medical Society, the Chairman of the Council, and Chairman of the Commission on Governmental Affairs will be ex officio members with vote. Nominations for membership on the commission shall be made by the Council Nominating Committee, but nominees shall be actively solicited from within each district by contact with the county medical societies and the medical staffs of hospitals. The commission shall be concerned with planning, organizing, and implementing appropriate programs to protect, promote, and achieve the socio-economic interests of the members of the State Medical Society of Wisconsin. It shall report to the Council at every regular meeting and annually to the House of Delegates, both as to its operations and policy recommendations.

LaVern H Herman, MD, Waukesha, 1980
William L Treacy, MD, Milwaukee, 1980
Charles E Pechous, Jr, MD, Kenosha, 1980
Jordon Frank, MD, Beloit, 1980
Vice-chairman
Charles N Ford, Jr, MD, LaCrosse, 1980
Russell Quirk, MD, Racine, 1981
Frederick C Kriss, MD, Madison, 1981
Joseph C Diraimondo, MD, Manitowoc, 1981
John F Just, MD, Milwaukee, 1981
Richard Stone, MD, Milwaukee, 1981
Kenneth M Viste, MD, Oshkosh, 1982
Chairman
Matthew Meyer, MD, Waukesha, 1982
John Simenstad, MD, Osceola, 1982
Harry H Larson, MD, Ashland, 1982
John E Thompson, MD, Nekoosa, 1982

Ex officio voting members:
President, State Medical Society
Chairman of the Council
Chairman, Commission on Governmental Affairs

COMMISSION ON HEALTH PLANNING

This commission shall be concerned about planning for health care, including facilities and services and their organization to assure availability, access and quality of care; standards, guidelines and regulations affecting health care; distribution of medical services; relationships with allied health personnel; and matters pertaining to the Joint Commission on Accreditation of Hospitals.

Marvin G Parker, MD, Racine, 1980
Donald R Korst, MD, Madison, 1980
Frederic L Hildebrand, MD, Neenah, 1980
John D Hart, MD, Shawano, 1981
Guenther Pohlmann, MD, Milwaukee, 1981
D Joseph Freeman, MD, Wausau, 1981
Edward J Lennon, MD, Milwaukee, 1982
Bruce J Stoehr, MD, Green Bay, 1982
Kermit L Newcomer, MD, LaCrosse, 1982

This commission also includes representatives of specialty sections/societies and chairmen of Physician HSA Task Forces with voting rights when present, provided they are SMS members, such appointments subject to approval by the Council.

COMMITTEES

COMMITTEE ON AGING AND EXTENDED CARE FACILITIES

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care.

Joseph Springberg, MD, Beloit, 1980
Frederick W Blancke, MD, Madison, 1980
Gertrude Howe, MD, Fish Creek, 1980
Nicholas L Owen, MD, Milwaukee, 1981
W E Rosenkranz, MD, Mukwonago, 1981
John E Thompson, MD, Nekoosa, 1981
Elston L Belknap, Jr, MD, Madison, 1982
Edward Perry, MD, LaCrosse, 1982
Leslie H Stone, MD, Oshkosh, 1982

COMMITTEE ON ALCOHOLISM AND OTHER DRUG ABUSE

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Darold A Treffert, MD, Winnebago, 1980
Eugene J Kinder, MD, Spring Green, 1980
Edward C Schmidt, MD, Milwaukee, 1980
Ronald L Harms, MD, Shawano, 1981
Warren H Williamson, MD, Racine, 1981
Fred H Koenecke, MD, Madison, 1981
Roland Herrington, MD, Milwaukee, 1982
Marwood E Wegner, MD, St Croix Falls, 1982
Alan E Reed Jr, MD, Wauwatosa, 1982

COMMITTEE ON CANCER

This committee shall be concerned about the cause, diagnosis, prevention, and alleviation of human cancer.

Glenn A Smiley, MD, Delavan, 1980
Ralph C Frank, MD, Eau Claire, 1980
James J Tydrich, MD, Richland Center, 1980
John D Hurley, MD, Milwaukee, 1981
Robert E Carlovsky, MD, Fond du Lac, 1981
John J Smalley, Jr, MD, LaCrosse, 1981
John K Scott, MD, Madison, 1982
Donald A Jeffries, MD, Shawano, 1982
Marcia Richards, MD, Milwaukee, 1982

COMMITTEE ON MATERNAL AND CHILD HEALTH

This committee shall be concerned about all aspects of health in pregnancy, childbirth, and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

David V Foley, MD, Milwaukee, 1980
James C Tankersley, MD, LaCrosse, 1980
John E Inman, MD, Monroe, 1980
Richard C Brown, MD, Eau Claire, 1981
Walter R Schwartz, MD, Wauwatosa, 1981
Raymond E Burrill, MD, Marshfield, 1981
Kilian H Meyer, MD, Richland Center, 1982
Edward Buerger, MD, Waukesha, 1982
Curtis R Weatherhogg, MD, Madison, 1982

COMMITTEE ON MEDICINE AND RELIGION

This committee shall be concerned about the medical-spiritual values of health care and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

Maxwell Weingarten, MD, Milwaukee, 1980
John K Scott, MD, Madison, 1980
E Basil Jackson, MD, Milwaukee, 1980
Richard W Shropshire, MD, Madison, 1981
Frank J Cerny, MD, Fond du Lac, 1981
Roger Evans, MD, LaCrosse, 1981
John O Simenstad, MD, Osceola, 1982
John S Harris, MD, Appleton, 1982
John P Mullooly, MD, Milwaukee, 1982

COMMITTEE ON MENTAL HEALTH

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total well-being.

Francis M Forster, MD, Madison, 1980
Theodore J Nereim, MD, Mount Horeb, 1980
Edward Meyer, MD, Oshkosh, 1980
Charles W Landis, MD, Milwaukee, 1981
C E Moore, MD, Fond du Lac, 1981
Robert F Goerke, MD, Milwaukee, 1981
David P Donarski, MD, Green Bay, 1982
William H Heywood, MD, Marshfield, 1982
Pauline Jackson, MD, LaCrosse, 1982
William Garitano, MD, Marshfield, 1982
Terry Hankey, MD, Waupaca, 1982
Warren Olson, MD, Madison, 1982

COMMITTEE ON OCCUPATIONAL HEALTH

This committee shall be concerned about the health and safety of persons in relation to their occupation. This shall include matters concerning Worker's Compensation.

John T Bruton, MD, Racine, 1980
John W Faber, MD, Neenah, 1980
Louis Olsman, MD, Kenosha, 1980
Carl Zenz, MD, West Allis, 1981
Kenneth R Peters, MD, Menomonee Falls, 1981
Robert Dedmon, MD, Neenah, 1981
Charles W Fishburn, MD, New Berlin, 1982
Donald M Rowe, MD, Kohler, 1982
William C Curtis, MD, Milwaukee, 1982

COMMITTEE ON RURAL HEALTH

This committee shall be concerned with the special problems related to assuring adequate medical and health care for those who live in rural areas.

Edward J Stack, MD, Superior, 1980
Timothy A Correll, MD, Dodgeville, 1980
Burton K Smith, MD, Wausau, 1980
Donald Welter, MD, Milwaukee, 1981
John J Beck, MD, Sturgeon Bay, 1981
Boyd Groth, MD, Mosinee, 1981
George H Handy, MD, Madison, 1982
Walther W Meyer, MD, Medford, 1982
Robert A Starr, MD, Viroqua, 1982

This committee also will assign farm trauma program and National Health Service Corps physician placements.

COMMITTEE ON SCHOOL HEALTH

This committee shall be concerned about protecting and improving the health of those attending the public or private schools of this state, including matters related to athletics.

William T Brodhead, MD, Madison, 1980
Frank Walker, MD, Brookfield, 1980
Lawrence K Siegel, MD, Waukesha, 1980
George H Handy, MD, Madison, 1981
Horace K Tenney, III, MD, Madison, 1981
Edward Zupanc, MD, Monroe, 1981
James C H Russell, MD, Ft Atkinson, 1982
Parnell Donahue, MD, Hartford, 1982
Dennis K Ryan, MD, LaCrosse, 1982

COMMITTEE ON SAFE TRANSPORTATION

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

Clarence E Moore, MD, Fond du Lac, 1980
James M Huffer, MD, Madison, 1980
Elmer E Johnson, MD, Madison, 1980
James L Weygandt, MD, Sheboygan Falls, 1981
Fred Bunkfeldt, Jr, MD, Milwaukee, 1981
Glenn C Hillery, MD, Lancaster, 1981
Eugene Eckstam, MD, Monroe, 1982
Ralph F Hudson, MD, Eau Claire, 1982
Walter F Smejkal, MD, Manitowoc, 1982

COMMITTEE ON ENVIRONMENTAL HEALTH of the Commission on Governmental Affairs

Wendelin Schaefer, MD, Sheboygan
Chairman
Barry Bast, MD, Manitowoc
Melvin Blumenthal, MD, Monroe
Phillip M Green, MD, Marshfield
Larry A Lindesmith, MD, LaCrosse
Mrs Wendelin Schaefer, Sheboygan
John T Schmitz, MD, Milwaukee
Burton A Waisbren, Jr, MD, Milwaukee
Frank A Walker, MD, Brookfield
Carl Zenz, MD, West Allis

COMMITTEE ON FEDERAL LEGISLATION of the Commission on Governmental Affairs

Robert F Purtell, Jr, MD, Milwaukee
Chairman
John Foreman, MD, Racine
Stephen Imbeau, MD, Middleton
Robert Lotz, MD, Eau Claire
Robert Toohill, MD, Milwaukee
Raymond Zastrow, MD, Hartland
Clarence Jordahl, MD, Milwaukee
David Weber, MD, Fond du Lac
Michael P Mehr, MD, Marshfield
Carl Eisenberg, MD, Milwaukee
Vacancy

Ex Officio:
Joseph M Lubitz, MD, Oconomowoc
Mrs Daniel Shea, DePere

COUNCIL COMMITTEES for 1979-1980 will appear in a future issue of WMJ.

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County Medical Societies

Presidents, Secretaries and Meeting Schedules

County	*President*	*Secretary*	*Meetings*
Ashland—Bayfield—Iron	Howard N V Sandin, Suite 9, 2101 Beaser Ave, Ashland 54806	Garfield W Brown, 2101 Beaser Ave, Ashland 54806	On-call
Barron—Washburn—Burnett	James A Rugowski, Rte 1, Box 146A, Cumberland 54829	Donald E Riemer, PO Box 127, Cumberland 54829	Second Tuesday of month
Brown	Bernard P Waldkirch, 502 George St, DePere 54115 *Treasurer:* Frederick J Lamont, 123 N Military Ave, Green Bay 54303	James R Mattson, 501 S Military Ave, Green Bay 54301 *Executive Secretary:* Ms Bernice Mangless, 501 S Military Ave, Green Bay 54301	Second Thursday of month
Calumet	Francis P Larme, 2020 Madison St, New Holstein 53061	James C Pinney, 507-C West Main St, Hilbert 54129	On-call
Chippewa	Gordon H Rosenbrook, 1518 Main St, Bloomer 54724	Frederick D Cook, 1315 Ridgewood, Chippewa Falls 54729	First Tuesday of month
Clark	Ana C Capati, RFD 3, Box 257, Neillsville 54456	A Mitat Algan, 400 Mill St, Loyal 54446	On-call
Columbia—Marquette—Adams	Muzaffar Mirza, 333 S Linden St, Adams 53910	Fredrick H Bronson, RR #2, Fox Glen Rd, Portage 53901	On-call
Crawford	Thomas F Farrell, 323 S Beaumont Rd, Prairie du Chien 53821	Michael S Garrity, 610 East Taylor St, Prairie du Chien 53821	On-call
Dane	J D Kabler, 1552 University Ave, Madison 53706	William J Hisgen, 20 S Park St, Madison 53715	First Tuesday of month
Dodge	Joseph M Militello, 707 S University Ave, Beaver Dam 53916	Norman J Schroeder II, 1200 Center St, Beaver Dam 53916	Last Thursday of month
Door—Kewaunee	Hansi R Patience, Park Farm Route 5, Sturgeon Bay 54235	Roland G Evenson, 535 South 8th Ave, Sturgeon Bay 54235	Fourth Tuesday of month, Sept thru May
Douglas	William D Berg, 620 North 23rd St, Superior 54880	Lawrence F Reich, 318 21st Ave, East, Superior 54880	First Wednesday of month
Eau Claire—Dunn—Pepin	Jack D Edson, PO Box 224, Eau Claire 54701	J Randall Dennison, 733 West Clairemont Ave, Eau Claire 54701	Fourth Monday of month
Fond du Lac	Harry J Zemel, 430 East Division St, Fond du Lac 54935 *Treasurer:* David F Sweet, 80 Sheboygan St, Fond du Lac 54935	James E Schuster, 333 North Peters Ave, Fond du Lac 54935	Fourth Thursday of month
Forest	Enzo F Castaldo, Laona 54541	Burton S Rathert, 101 W Washington Crandon 54520	On-call
Grant	C L Steidinger, 1370 North Water St, Platteville 53818	John J David, Cassville 53806	On-call
Green	Carlos A Jaramillo, PO Box 596, Monroe 53566	Joseph J Dimartini, 1515 10th St, Monroe 53566	Third Monday of month, Feb, Apr, June, Aug & Nov
Green Lake—Waushara	Roy Hong, Rte 2, Wild Rose 54984	Pepito M Emlano, PO Box 314, Wild Rose 54984	On-call
Iowa	Young I Kim, 109 West Fountain St, Dodgeville 53533	Harald P L Breier, 207 Main St, Montfort 53569	Second Tuesday of month, recess for summer
Jefferson	Ruth Schuh, 907 Clyman St, Watertown 53094	George L Gay, PO Box 28, Cambridge 53523	Third Thursday of month
Juneau	Clayton L Weston, 600 South Monroe, New Lisbon 53950	Jack Strong, 143 Division, Mauston 53948	On-call
Kenosha	John N Richards, 6215 10th Ave, Kenosha 53140 *Executive Secretary:* Mr Mark J Gorman, 3916 67th St, Kenosha 53140	A James Bennett, 3618 8th Ave, Kenosha 53140	First Thursday of month

County	President	Secretary	Meetings
LaCrosse	James T Murphy, 212 S 11th St, LaCrosse 54601	Stephen B Webster, 1836 South Ave, LaCrosse 54601	Third Monday of month
Lafayette	No Members in County Society		
Langlade	John E McKenna, PO Box 400, Antigo 54409		
Lincoln	Nunillo L Bugarin, 221 East Washington Ave, Tomahawk 54487	Muhammad Y Ahmad, 716 East Second St, Merrill 54452	Fourth Tuesday of month, Sept thru May
Manitowoc	David D Pfaffenbach, 1119 Marshall St, PO Box 705, Manitowoc 54220	Edward J Barylak, 601 Reed Ave. PO Box 279, Manitowoc 54220	Last Tuesday of month
Marathon	William C Miller, 808 Third St, Wausau 54401	Bruce C Rhoades, 1100 Lakeview Dr, Wausau 54401	Last Monday of month
Marinette—Florence	Thomas F Foley, 1510 Main St, Marinette 54143	James A Boren, 1510 Main St, Marinette 54143	Third Wednesday of month
Milwaukee	Derward Lepley Jr, 9800 W Bluemound Rd, Milwaukee 53226 *Executive Vice-President:* Mr Michael McManus, 411 East Mason St, Milwaukee 53202	William E Finlayson, 2003 West Capitol Dr, Milwaukee 53206	Dec (Annual), Feb, June & Oct
Monroe	Gustave A Landmann, PO Box 729, Tomah 54660	Jack D Brown, 202 South K St, Sparta 54656	Second Monday of month
Oconto	John S Honish, MD, 1113 N Main St, Oconto 54153	David P Losh, 907 Main St, Oconto 54153	Third Tuesday of month
Oneida—Vilas	George Nemec Jr, Rte 1, Box 171A, Woodruff 54568	Paul H K Figge Jr, 1020 Kabel Ave, Rhinelander 54501	On-call
Outagamie	William B Grubb Jr, 424 E Wisconsin Ave, Appleton 54911	William R Richards, 900 E Grant St, Appleton 54911	Third Thursday of month
Ozaukee	Robert A Pfeffer, 118 East Grand Ave, Port Washington 53704	Domingo T Hong, 1971 Washington St, Grafton 53024	Fourth Thursday of month
Pierce—St Croix	George M Pope, Rte 2, Box 33, River Falls 54022	David M Woeste, 409 Spruce St, River Falls 54022	Third Tuesday of month
Polk	Herbert A Dasler, 127 Keller Ave, North, Amery 54001	Marwood E Wegner, 208 Adams St, South, St Croix Falls 54024	Third Thursday of month
Portage	Vacancy	Daniel L Brick, 2501 Main St, Stevens Point 54481	
Price—Taylor	James G Sargeant, 500 Birch St, Park Falls 54552	Walther W Meyer, 101 North Gibson Ave, Medford 54451	Quarterly
Racine	James R Hammes, 500 Walton Ave, Racine 53402 *Executive Secretary:* Mr Gilbert J Berthelson, PO Box 592, Racine 53401	Huron L Ericson, 12 Raven Turn, Racine 53402 *Treasurer:* Victoriano A Baylon, 3801 Spring St, Racine 53405	Third Thursday of month
Richland	Kilian H Meyer, 1313 West Seminary St, Richland Center 53581	L Maramon Pippin, 1313 West Seminary St, Richland Center 53581	First Thursday of month
Rock	Walter A Scholten Jr, 1905 Huebbe Parkway, Beloit 53511	Thomas M Shearer, 1011 North Main St, Edgerton 53534	On-call
Rusk	Raymond R Johnson, 906 College Ave, West, Ladysmith 54848	James E Madsen, 906 College Ave, West, Ladysmith 54848	Third Tuesday of month
Sauk	John J Koch, 55 Prairie Ave, Prairie du Sac 53578	Paul R Bishop, 55 Prairie Ave, Prairie du Sac 53578	Second Tuesday of month, Sept thru May
Sawyer	Lloyd M Baertsch, Rte 6, Box 700, Hayward 54843	Paul Strapon III, Rte 6, Box 700, Hayward 54843	
Shawano	R David Petty, 117 East Green Bay St, Shawano 54166	Alois J Sebesta, 126½ South Main St, PO Box 311, Shawano 54166	Fourth Monday of month
Sheboygan	Bernard S Marsho, 531 North 7th St, Sheboygan 53081	Donald D Ohme, 1011 North 8th St, Sheboygan 53081	Third Thursday of month

continued on next page

County	*President*	*Secretary*	*Meetings*
Trempealeau—Jackson—Buffalo	Paul B Christianson, 610 West Adams St, Black River Falls 54615	James J Dickman II, 610 West Adams St, Black River Falls 54615	Fourth Tuesday of month
Vernon	Phillips T Bland, 100 Melby St, Westby 54667	DeVerne W Vig, 125 West Jefferson, Viroqua 54665	On-call
Walworth	Menandro Tavera Jr, Rte 4, Box 126, Lake Geneva 53147	Edsel G Doreza, Kenosha St, Walworth 53184	Third Thursday of month
Washington	William J Listwan, 279 S 17th Ave, PO Box 178, West Bend 53095	James F Baumgartner, 279 South 17th Ave, PO Box 178, West Bend 53095	Fourth Thursday of month, except July, Aug & Dec
Waukesha	LaVern H Herman, 1200 Sweetbriar Dr, Waukesha 53186 *Executive Secretary:* Mr Robert Herzog, 850 Elm Grove Rd, Elm Grove 53122	Michael McCormick, 102 East Main St, Waukesha 53186 *Treasurer:* Matthew A Meyer, 217 Wisconsin Ave, Waukesha 53186	First Wednesday of month
Waupaca	Terry L Hankey, 710 Riverside Dr, PO Box 387, Waupaca 54981	Jerry R Salan, 710 Riverside Dr, PO Box 387, Waupaca 54981	Second or Third Thursday of month
Winnebago	Harry J Colgan, 1215 Doctors Dr, Neenah 54956	Charles R Lyons, 2000 East Murdock Ave, Oshkosh 54901	First Thursday of month, except July & Aug
Wood	Paul S Treuhaft, 1000 N Oak Ave, Marshfield 54449	Homer Russ, 611 St Joseph Ave, Marshfield 54449	On-call ■

All officers are MDs unless Mr or Mrs is indicated.

Are you wasting Disability dollars?

RECENT SURVEYS indicate that a majority of physicians carry adequate amounts of disability insurance. Unfortunately, some of these dollars are being wasted either as premiums are paid or as benefits are received. The reason—many physicians who are adequately insured for disability have no "Business Overhead Expense Insurance." As a consequence when disability strikes, a portion of the benefit paid must be used for continuing office expenses.

Let's define these two terms and also examine the differences between them. By so doing, the proper and most profitable usage of each will be clearly illustrated.

DEFINITIONS:

Disability income insurance:
Used to provide income for *personal* needs during a period of temporary or permanent disability.

Business overhead insurance:
Used to provide monies to pay ongoing practice operating expenses during a period of temporary disability (rent-heat-light-secretarial, etc).

DIFFERENCES:

Disability insurance

More expensive per dollar coverage.

If used for BOE, fewer dollars available for *personal* use.

Premiums *not* tax deductible for the individual.

Maximum deduction allowed on the Federal Income Tax of $5,200 per year, if total premium paid by individual.

Taxed as ordinary income if premiums paid by employer.

Business overhead expense insurance

Less expensive per dollar coverage.

No effect on dollars available for personal use. Premiums *are* tax deductible.

Benefits taxable, but as they are used to pay BOE they become fully tax deductible.

The above clearly illustrates the need to audit your insurance coverage ensuring that each of these valuable instruments is being used properly and to their greatest respective advantages. ■

In Edema* or Hypertension* when potassium balance is a concern...

Potassium-Sparing

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Makes Sense

In Edema

The triamterene in 'Dyazide' limits potassium loss and provides an additive diuretic effect to that of the hydrochlorothiazide component.

In Hypertension

As the hydrochlorothiazide in 'Dyazide' lowers blood pressure, the triamterene component limits potassium loss.

Serum K^+ and BUN should be checked periodically particularly in the elderly, diabetics, and those with suspected or confirmed renal insufficiency (see Warnings). If hyperkalemia develops, substitute a thiazide alone.

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
a SmithKline company

SK&F CO.
Carolina, P.R 00630

When painful spasm is the presenting symptom . . .

...in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

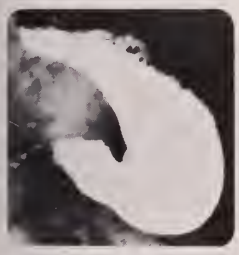
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste, headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence, suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*: 1 capsule or teaspoonful syrup three or four times daily. *Infants*: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*: 1 tablet three or four times daily. Bentyl Injection: *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215 U S A

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Socety.

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INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/ Clinical Practice."

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Council and Officers of the State Medical Society and up to ten elected non-medical persons. In addition each of the 54 component county societies may elect a representative who is considered a corporate member of the Board. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

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Historian: Mrs C Malcolm Scott, 11 St Alban's Road, Superior 54880

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Mrs Laverne Bartel, 330 East Lakeside St, Madison 53705 ■

PAST PRESIDENTS OF THE STATE MEDICAL SOCIETY OF WISCONSIN: 1953-1979

This is a partial listing. The complete listing from 1841 to 1972 appeared in the January 1973 issue. There is one living past president not included in this listing. He is Matthew A McGarty, MD, LaCrosse, who served in 1920-1921.

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Arthur J McCarey, MD. †Green Bay 1954-1955
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L Otis Simenstad, MD, †Osceola 1956-1957
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Roy B Larsen, MD, Wausau 1977-1978
Jules D Levin, MD, Milwaukee 1978-1979

† Deceased

MEDICAL COMMUNICATION COLLECTION ESTABLISHED AT THE UNIVERSITY OF ILLINOIS MEDICAL CENTER CAMPUS

A medical communication collection, consisting of more than 3,330 references, reprints, books, journals and other materials on medical photography, medical motion pictures, medical television and continuing medical education, has been presented to the Library of the Health Sciences, University of Illinois at the Medical Center, Chicago.

Known as the Ralph Creer Collection, it is one of the most complete and useful resource facilities of its kind in the country. It will provide scholars an opportunity to research, review and re-evaluate various past approaches to medical communication.

All the materials have been donated from the personal collection of Ralph Creer, a consultant in medical communications.

Creer, who is the immediate past director of the American Medical Association's (AMA) Department of Scientific Assembly, has devoted his entire career to medical communications. His collection has been assembled from all over the world during a span of 40 years.

Among the materials in the collection are:

—medical motion picture reprints that are primarily concerned with development and utilization of films as a teaching media. They represent the era from post-world War II to 1960. A special historical section contains portions of a manuscript on films that was prepared for the U.S. Navy Department of Medicine and a series of translated articles covering a period as far back as 1895.

—more than 150 articles on the development and utilization of television in medicine and surgery for undergraduate and post-graduate education.

—articles that deal with various methods and patterns in continuing medical education.

Creer, who was associated with the AMA for 27 years, was also director of the Division of Photography at Yale University School of Medicine (1928-33).

He is also director of the Health Sciences Communications Association and founding member and past president of the Audiovisual Conference of Medical and Allied Sciences.

Other professionals are invited to donate similar materials to the collection.

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as of record June 8, 1979

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Delegate ..... Michael J Mally, MD, 1004 East Sumner St, Hartford 53027
Alternate ..... Vacancy

Sections are urged to notify the State Medical Society of their officers and delegates as soon as they are named so that communications to the sections can be sent during the ensuing year.

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Secretary-Treas ..... Vacancy
Delegate ..... Mark J Ciccantelli, MD, 1908 Forest St, Wauwatosa 53213
Alternate ..... Manucher J Javid, MD, 600 Highland Ave, Madison 53792

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Delegate ..... Michael McQuillen, MD, 8700 West Wisconsin Ave, Milwaukee 53226
Alternate ..... Vacancy

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Alternate ..... Hiro Nishioka, MD, 704 South Webster Ave, Green Bay 54301

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STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program

for Continuing Medical Education

Information is available in booklet form from: Arlene Meyer, Administrative Assistant for Continuing Medical Education, Health Services Division, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; or telephone toll-free in Wisconsin 1-800-362-9080 (x 132).

☆ ☆ ☆

On July 1, 1977, the Liaison Committee on Continuing Medical Education (LCCME) assumed from the American Medical Association (AMA) the responsibility for accreditation of institutions and organizations offering continuing medical programs and for the approval of state and territorial medical associations to conduct Survey for Accreditation Programs, which provide recommendations to the LCCME on accreditation of intrastate institutions and organizations.

The LCCME is composed of the following member organizations:—American Board of Medical Specialties, American Hospital Association, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, Council of Medical Specialty Societies, Federation of State Medical Boards of the United States, Inc.

The State Medical Society of Wisconsin accreditation operates under the authority of the LCCME, of which the AMA is a member organization. Accreditation by the SMSW is equivalent to action by the LCCME.

Following are the six categories of learning activities that are acceptable toward CME credit:

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CATEGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical teaching.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

continued on opposite page

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Alternate .....

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Alternate ..... Richard Biek, MD, Rte #4, Box 148J, Waupaca 54981

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UROLOGY

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CME Accreditation Program/continued

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED *by SMSW and LCCME for continuing medical education programing at March 1, 1979*

Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Deaconess Hospital, Milwaukee
Ft Atkinson Memorial Hospital, Ft Atkinson
Gundersen Medical Foundation Ltd & LaCrosse Lutheran Hospital, LaCrosse
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Memorial Hospital of Iowa County, Dodgeville
Methodist Hospital, Madison
Mount Sinai Medical Center, Milwaukee
Osseo Area Municipal Hospital, Osseo
Sacred Heart Hospital, Eau Claire
Sauk Prairie Memorial Hospital, Prairie du Sac
St Agnes Hospital, Fond du Lac
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Francis Hospital, La Crosse
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Mary's Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
St Michael Hospital, Milwaukee
St Vincent Hospital, Green Bay
Theda Clark Memorial Hospital, Neenah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Hospitals, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

American Heart Association, Wisconsin Affiliate
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
The Racine Academy of Medicine
State Medical Society Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Clinical Cancer Center
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolaryngological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Obstetrics & Gynecology
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

Marinette-Florence County Medical Society

AMA Accredited
Dept CME, Medical College of Wisconsin

Dept CME, UW Center for Health Sciences

Interstate Postgraduate Medical Association

The State Medical Society of Wisconsin

Wisconsin Society of Anesthesiologists

Recipients of Awards Presented by the State Medical Society of Wisconsin

COUNCIL AWARD

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M Dodd, MD† 1930
Cornelius A Harper, MD† 1930
John J McGovern, MD† 1931
Louis M Jermain, MD† 1931
Edward Evans, MD† 1931
Mina B Glasier, MD† 1932
Arthur W Rogers, MD† 1934
Rock Sleyster, MD† 1934
Olin West, MD† 1934
Edward A Birge, PhD† 1935
Arthur J Patek, MD† 1935
Joseph F Smith, MD† 1937
Eben J Carey, MD† 1938
William S Middleton, MD† 1938
Fred G Johnson, MD† 1939
William D Stovall, MD† 1940
Ludwig Hektoen, MD*† 1941
Stephen E Gavin, MD† 1944
F Gregory Connell, MD† 1947
E R Schmidt, MD† 1949
Armand J Quick, MD 1950
F A Stratton, MD† 1951
Gunnar Gundersen, MD† 1953
W J Meek, PhD† 1953
R G Arveson, MD† 1957
Edwin B Fred, PhD 1958
Harry Beckman, MD 1959
Elizabeth Comstock, MD† 1961
Harry Steenbock, PhD† 1963
Francis J L Blasingame, MD 1964
C N Neupert, MD† 1965
Spencer D Beebe, MD† 1965
Frank L Weston, MD** 1966
Robert E Fitzgerald, MD**† 1966
William B Walsh, MD 1967
H Kent Tenney, MD 1969
Charles H Crownhart, Esq† 1971
Thomas J Doran 1974
William B Hildebrand, MD† 1975
Roman E Galasinski, MD† 1975
Eugene J Nordby, MD 1976
Eli M Dessloch, MD 1977
Ben R Lawton, MD 1978
Howard L Correll, MD 1979

* Centennial Award. † Deceased.
** 125th Anniversary Award.

ERWIN R SCHMIDT INTERSTATE TEACHING AWARD

Since 1966, presented annually by the Interstate Postgraduate Medical Association to a faculty member of one of the two Wisconsin medical schools who has distinguished himself as a teacher of medical students and in preparing them for both the art and practice of medicine. Selected upon recommendation of the Commission on Continuing Medical Education, the Award is given in honor of Erwin R Schmidt, MD, who was chairman of surgery at the University of Wisconsin Medical School.

William S Middleton, MD,† Madison 1966
Walter Zeit, PhD, Milwaukee 1967
Paul F Clark, PhD, Madison 1968
Walter P Blount, MD, Milwaukee 1969
Ovid O Meyer, MD,† Madison 1970
William W Engstrom, MD, Milwaukee 1971
Otto A Mortenson, MD, Madison 1972
Albert G Schutte, MD, Milwaukee 1973
Lester W Paul, MD,† Madison 1974
John C Peterson, MD, Milwaukee 1975
Edgar S Gordon, MD,† Madison (posthumously) 1976
Warner S Bump, MD, Rhinelander 1979

PRESIDENTIAL CITATION AWARD

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a non-physician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission) 1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library) 1962
The Rev Edward J O'Donnell, S J (Chancellor of Marquette University) 1963
Harvey Higley (Former Administrator of Veterans Affairs), Marinette 1965
Francis J Wilcox (National Board Chairman, American Cancer Society, and Board of Directors, Wisconsin Division, ACS), Eau Claire 1966
Warren P Knowles (Governor of the State of Wisconsin), Madison 1967
Leo C Massopust (Scientific photographer, artist, and editor), Milwaukee 1968
Karl F Schmidt, PhD (Associate Director for Radio [WHA] at University of Wisconsin), Madison 1969
The Most Rev Father Carl Mansfeld, Milwaukee 1970
Roy T Ragatz (Executive Director, Interstate Postgraduate Medical Association), Madison 1971
The Hon John W Byrnes (US Congressman from Wisconsin), Green Bay 1972
Betty Anick (Recipient of first heart transplant in Midwest), Milwaukee 1973
T A Duckworth (Executive Vice-President of Employers Insurance of Wausau), Wausau 1974
Robert B L Murphy, Esq (Society Legal Counsel) 1977
Volunteer Physicians of the Green Bay Area Free Clinic, Ltd 1979

CIVIC LEADERSHIP AWARD

Established by the Council in 1972, the Civic Leadership Award recognizes a member of the State Medical Society of Wisconsin for his outstanding contributions in the activities of his community and the medical society.

John M Bell, MD, Marinette 1972
George A Behnke, MD, Kaukauna 1973
Harold J Kief, MD, Fond du Lac 1974
L Otis Simenstad, MD, Osceola 1974
H Kent Tenney, MD, Madison 1976
George H Handy, MD, Madison 1977
Paul B Mason, MD, Sheboygan 1978

GUNNAR GUNDERSEN GOLD MEDALLION AWARD

Established in 1966 during the State Medical Society's 125th anniversary to honor one of Wisconsin's most distinguished physicians and citizens, Gunnar Gundersen, MD of LaCrosse, who is a former president of the American Medical Association and the State Medical Society of Wisconsin. Presented by the Society for the scientific exhibit judged to be the most outstanding teaching exhibit in surgery at the Annual Meeting.

Joseph C Darin, MD, Wauwatosa *(Extracorporeal Hepatic Support System)* 1967
Flavio Puletti, MD, Madison *(Stereotactic Surgery in Parkinson's Disease)* 1968
Allen J Pois, MD; John Morledge, MD; Gordon A Tuffli, MD; and Peter Rank, MD; Jackson Clinic and Methodist Hospital, Madison *(Atrial Septal Defect, Diagnosis and Treatment)* 1969
William M Toyama, MD, Marshfield *(Open Pulmonary Biopsy in Children)* 1970
Robert J Flemma, MD; G W Beddingfeld, MD; Derward Lepley, Jr, MD; Jack C Manley, MD; Howard J Zeft, MD; Henry H Gales, MD; H David Friedberg, MD; W Dudley Johnson, MD; Alfred J Tector, MD; John A Walker, MD; Donald R McRaven, MD; John H Huston, MD; Felix E Tristani, MD; Ramon L Lange, MD; and Michael H Keelan, MD; Medical College of Wisconsin; St Luke's Hospital; Veterans Administration Hospital; and Milwaukee County General Hospital, Milwaukee *(Aorto-Coronary Bypass Grafts —Early and Late Followup Studies)* 1972

DISTINGUISHED SERVICE AWARD

The Council, upon recommendation of the Commission on Continuing Medical Education, may on occasion grant the Distinguished Service Award in recognition of outstanding contributions to the science and art of medicine by individuals engaged in teaching and research in the basic sciences.

Armand J Quick, MD, Milwaukee 1964
Otto A Mortensen, MD, Madison 1967
Walter Zeit, PhD, Milwaukee 1972
Thomas A Leonard, MD, Middleton 1977

HOUGHTON MEDICAL STUDENT AWARD

Granted annually to a student from each of Wisconsin's two medical schools who, through scholastic excellence, extracurricular achievement, and interest in medical organization, show high promise of becoming a complete physician. Established by MDs John H and William J Houghton, brothers, who were councilors of the State Medical Society of Wisconsin; John H also was president. Established in 1968 through funds contributed to the Society's Charitable, Educational and Scientific Foundation.

James Renne, Kenosha (University of Wisconsin Medical School) 1968
C Robert Stanhope, Milwaukee (Marquette School of Medicine) 1968
Bruce D Buchanan (Marquette School of Medicine) 1969
Daniel D Kane (University of Wisconsin Medical School) .. 1969
Stephen A Bernsten, Skokie, Ill (University of Wisconsin Medical School) 1970
Arthur W Kaemmer, Fond du Lac (Marquette School of Medicine) 1970
Winston Hollister, Milwaukee (Medical College of Wisconsin) 1971
Daniel Leicht, Racine (UW Medical School) 1971
James B Johnson (Medical College of Wisconsin) 1972
Eliot J Huxley (UW Medical School) 1972
Ted P Bronson (University of Wisconsin Medical School) .. 1973
Michael Krentz (Medical College of Wisconsin) 1973
Richard Adams (Medical College of Wisconsin) 1974
Jeffrey D Davis (University of Wisconsin Medical School) .. 1974
Kenneth L Bussan (University of Wisconsin Medical School) 1975
Stuart J Schneller (Medical College of Wisconsin) 1975
Dale Reid (University of Wisconsin Medical School) 1976
Joshua Trabulus (Medical College of Wisconsin) 1976
Diana L Kruse (University of Wisconsin Medical School) .. 1977
Daniel R Wartinbee (Medical College of Wisconsin) 1977
Richard Immler (University of Wisconsin Medical School) .. 1978
Margaret Chen (Medical College of Wisconsin) 1978
Ann Bartos Merkow (University of Wisconsin Medical School) 1979
Douglas Jackson (Medical College of Wisconsin) 1979

ELVEHJEM MEMORIAL LECTURE AWARD

Established in 1962 by the Council to honor the memory of Conrad A Elvehjem, PhD, the thirteenth president of the University of Wisconsin and an international authority in biochemistry. It is presented through auspices of the Society's Charitable, Educational and Scientific Foundation and is designed to perpetuate Doctor Elvehjem's contributions to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians. Lecturers are selected by the Commission on Continuing Medical Education for participation in the Annual Meeting scientific program.

Fredrick J Stare, MD, Boston, Mass 1963
John B Henry, MD, Syracuse, NY 1965
Jeremiah Stamler, MD, Chicago, Ill 1967
David Y-Yung Hsia, MD, Chicago, Ill 1968
James E McGuigan, MD, Gainesville, Fla 1970
Harry S Jacob, MD, Minneapolis, Minn 1971
A L Schroeter, MD, Rochester, Minn 1972
Frederick C Goetz, MD, Minneapolis, Minn 1973
Jack A Vennes, MD, Minneapolis, Minn 1974
Sydney M Finegold, MD, Los Angeles, Calif 1975
Adolph M Hutter Jr, MD, Boston, Mass 1976
Andre J Nahmais, MD, Atlanta, Ga 1977
Kevin Parent, MD, Marshfield 1978
Joseph J Barboriak, ScD, Wood 1979

BEAUMONT MEMORIAL LECTURE AWARD

Established in 1957 by the Council to memorialize one of Wisconsin's early frontier surgeons. Sponsored by the Society's Charitable, Educational and Scientific Foundation, it is designed to present to members of the Society distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. Lecturers are selected by the Commission Educational and Scientific Foundation, it is designed to present to on Continuing Medical Education for participation in the Annual Meeting scientific program.

Burill B Crohn, MD, New York, NY 1958
Franz J Ingelfinger, MD, Boston, Mass 1959
Mr Charles W A Falconer, Edinburgh, Scotland 1960
J L A Roth, MD, Philadelphia, Pa 1961
Ivan Baranosky, MD, San Diego, Calif 1963
David Y-Yung Hsia, MD, Chicago, Ill 1964
Alton Ochsner, MD, New Orleans, La 1965
Michael DeBakey, MD, Houston, Tex 1966
F A Simeone, MD, Cleveland, Ohio 1967
John S Najarian, MD, Minneapolis, Minn 1968
Oliver H Beahrs, MD, Rochester, Minn 1969
Warner S Bump, MD, Rhinelander, Wis 1970
John P Wyatt, MD, Winnipeg, Manitoba, Canada 1971
Richard H Egdahl, MD, Boston, Mass 1972
Walter F Ballinger, MD, St. Louis, Mo 1973
Frank G Moody, MD, Salt Lake City, Utah 1974
Edward J Beattie, MD, New York, New York 1975
Francis D Moore, MD, Boston, Mass 1976
Robert Zeppa, MD, Miami, Fla 1977
David B Skinner, MD, Chicago, Ill 1978
Edward L Bradley III, MD, Atlanta, Ga 1979

FIFTY YEAR CLUB AWARDS—1979

Annually the State Medical Society of Wisconsin pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity.

Herbert M Aitken, MD .....Eau Claire
D Murray Angevine, MD .....Madison
David J Ansfield, MD .....Milwaukee
Hugo M Bachhuber, MD .....Wausau
Benjamin I Brindley, MD .....Madison
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Paul A Lee, MD .....Santa Cruz, Calif
Edward L Martineau, MD .....Milwaukee
Edward R McNair, MD .....Orfordville
Jerry W McRoberts, MD .....Sheboygan
Otto A Mortensen, MD .....Menlo Park, Calif
Nina T Mueller, MD .....Hales Corners
Arthur H Olsen, MD .....Milwaukee
Carlyle R Pearson, MD .....Baraboo
Albert Popp, MD .....Milwaukee
Earl C Quackenbush, MD .....Hartford
James R Regan, MD .....Wauwatosa
William B Rydell, MD .....Rice Lake
Darrell S Sharp, MD .....Hayward
Ernest V Stadel, MD .....Reedsburg
William H Studley, MD .....Milwaukee
John A Thranow, MD .....La Belle, Fla
Wilson J Troup, MD .....DePere
William B Walton, MD .....Milwaukee
Edward D Wilkinson, MD .....Elm Grove
William C Wojta, MD .....Fond du Lac
Calvin M Yoran, MD .....Wausau ■

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Secretary—W Stuart Sykes, MD (Sept 1979), 1005 Columbia Rd, Madison 53705

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WISCONSIN OTOLARYNGOLOGICAL SOCIETY

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Secretary—Charles N Ford, MD (April 1980), 1836 South Ave, LaCrosse 54601

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Secretary—Pauline Jackson, MD (May 1980), 2520 Sherwood Dr, LaCrosse 54601

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Secretary—Vaughn Demergian, MD (Apr 1980), 30 S Henry St, Madison 53703

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Secretary—Richard B Windsor, MD (May 1980), 1011 N 8th St, Sheboygan 53081

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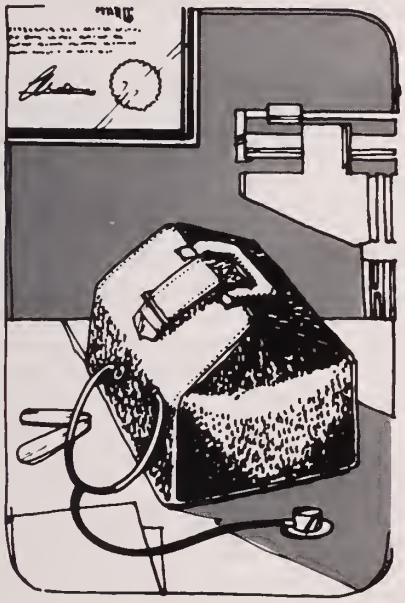
President—Kenneth L Day, MD (Apr 1980), 2727 Plaza Drive, Wausau 54401
Secretary—Charles W Troup, MD (Apr 1980), 2021 South Webster Ave, Green Bay 54301

To all my patients,

Partners in Good Health



The State Medical Society of Wisconsin announces a new program designed to improve physician-patient communications and encourage greater patient feedback.

The program, entitled "Partners in Good Health," contains statement stuffers, reception area brochures, patient feedback questionaires and a certificate of participation to be displayed in the reception area.

Program brochures are available in quantity by writing to:

The Communications Department
State Medical Society of Wisconsin
P.O. Box 1109
Madison, WI 53701

MUTUAL RESPECT

WORKING TOGETHER

EXCHANGE OF INFORMATION

QUESTIONS AND CONCERNS

INFORMED CONSENT

IN THE HOSPITAL

FEES FOR SERVICES

HEALTHY LIFESTYLE

Prepared and distributed
by the State Medical Society of Wisconsin

THE FOUNDATION FOR MEDICAL CARE EVALUATION OF SOUTHEASTERN WISCONSIN, INC

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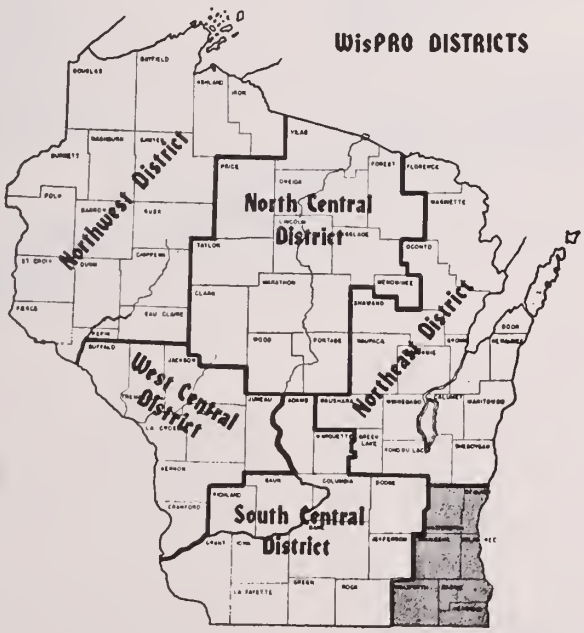


HELPING THE RETARDED, DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be mentally retarded.

A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. And a call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family in their county.

There should be local resources, psychological services, OT, etc available to complement the physician's examination. Also there are several clinics within the state that provide specialized evaluations for the persons who are mentally retarded and for persons with other developmental disabilities.

- CHILD DEVELOPMENT CENTER

  Dr June Dobbs, Director
  Child Development Center
  Milwaukee Children's Hospital
  1700 West Wisconsin Ave
  Milwaukee, Wisconsin
  (414) 931-4069

- UNIVERSITY HOSPITALS

  Dr Charles Schoenwetter
  H6 4th Floor, 600 Highland Ave
  Madison, Wisconsin 53792
  (608) 263-6421

- WAISMAN CENTER ON MENTAL RETARDATION

  Linne Cain, Intake Coordinator
  1500 Highland Ave
  Madison, Wisconsin 53706
  (608) 263-5777

- COMPREHENSIVE EVALUATION CLINIC FOR MULTIPLI-HANDICAPPED CHILDREN

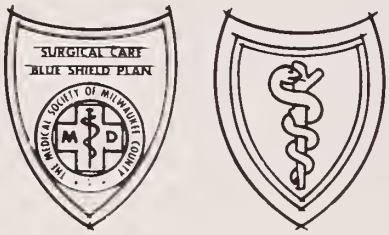
  Ms Marilyn Gratto
  Miller-Dwan Hospital
  502 East 2nd Street
  Duluth, Minnesota 55805
  (218) 727-8762

Further information may be obtained from Rosemarie Reed, Information and Referral Outreach, Wisconsin Association for Retarded Citizens, Inc, 2700 Laura Lane, Middleton, Wis 53562; (608) 831-3444.

Thank you, physicians of Wisconsin!

Surgical Care-Blue Shield has added an "Inc." after its name. This marks our incorporation — our official separation from the Medical Society of Milwaukee County, which founded our organization back in 1943.

We'd like to express, publicly, our appreciation to all of you who are members of Wisconsin's medical community, and especially those who are members of the Medical Society of Milwaukee County, for your support over the last 36 years. If it weren't for your help, we wouldn't have been able to serve our subscribers nearly as well as we have. Most noteworthy have been your assistance in cost containment, reviewing difficult claims and evaluating new medical procedures and contract benefits.



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With our incorporation, our board of directors will be voluntarily reconstituted — to 50% physicians, 50% consumers — to strengthen the public's voice in policy determination. Through this and our advantage of having your abiding cooperation, we will continue to provide our traditionally high level of surgical-medical benefits, on a not-for-profit basis, to over 1.3 million fellow Wisconsinites.*

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When the indications surface...

Net wt 1 oz

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NEOSPORIN® Ointment

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Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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A VALUABLE REFERENCE FOR PRACTICING PHYSICIANS AND ALLIED HEALTH PERSONNEL

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Lloyd Riddle

EPSDT—Early and periodic screening, diagnosis and treatment for children and other screening activities

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- Staffing of Health Policy Council and its committees
- Development of State Health Plan
- Liaison with Health Systems Agencies and review of their plans and budgets
- Coordination of categorical health planning process
- Review of categorical health plans
- Liaison with agencies (public and private) that implement the State Health Plan
- Development of emergency medical services systems

Needs Review 266-7384
- Review of 1122 capital expenditures
- Certificate of Need
- Service licensure
- Development of health facilities plan
- Review of categorical grants appeal
- Hospital rate review

Health Care Financing Control 266-2522
- Administration of the Medical Assistance Program
- Promotion of plans for prepayment of comprehensive health services
- Liaison with Office of the Insurance Commissioner

Quality Compliance 266-8847
- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards
- Laboratory certification

Prevention 266-1251
- Development and promotion of prevention programs
- Standard epidemiology
- Immunization activities
- Communicable diseases
- Chronic diseases
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Health education

Community Health 266-2661
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning

Institutional Health Services .266-5718
- Assurance of sufficient levels of physical health care for all inmates in correctional institutions and at Central State Hospital
- Management of the provision of such services to insure effectiveness and efficiency
- Recruitment and staffing of health care positions in the institutions

Environmental Health 266-1704
- Certification of Grade A milk
- Platting of unsewered subdivisions
- Septic tank regulation
- Plumbing and fire protection services
- Inspection of hotels, restaurants and food vending services where not performed by local public health agencies
- General environmental sanitation
- Recreational inspection
- Radiation protection
- Occupational health services

Health Statistics 266-1939
- Vital Statistics
- Resource data
- Demographic and special analysis
- Services data

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Tel 414/922-1290

No 4—GREEN BAY 54343
1181 Western Ave; PO Box 3860
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No 5—LACROSSE 54601
District State Office Building
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No 7—WISCONSIN RAPIDS 54494
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Tel 715/423-4730

No 7—RHINELANDER 54501
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Tel 715/369-2840

No 8—Information should be obtained from Eau Claire District

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DIVISION OF HEALTH

The Bureau is the custodian of birth, death, marriage, and divorce records for the state. Also, the Bureau has contracts with the National Center for Health Statistics, Cooperative Health Statistics System for the collection of data on health manpower, facilities, and vital statistics. Several other projects are being carried out in areas such as cancer reporting, emergency medical care, and hospital discharge data. Another of the Bureau's activities is the production of annual population estimates for Wisconsin counties . . . a part of the Federal-State Cooperative Program of the Bureau of the Census. Inquiries may be made to: Raymond D Nashold, Director, Bureau of Health Statistics, PO Box 309, Madison, Wis 53701.

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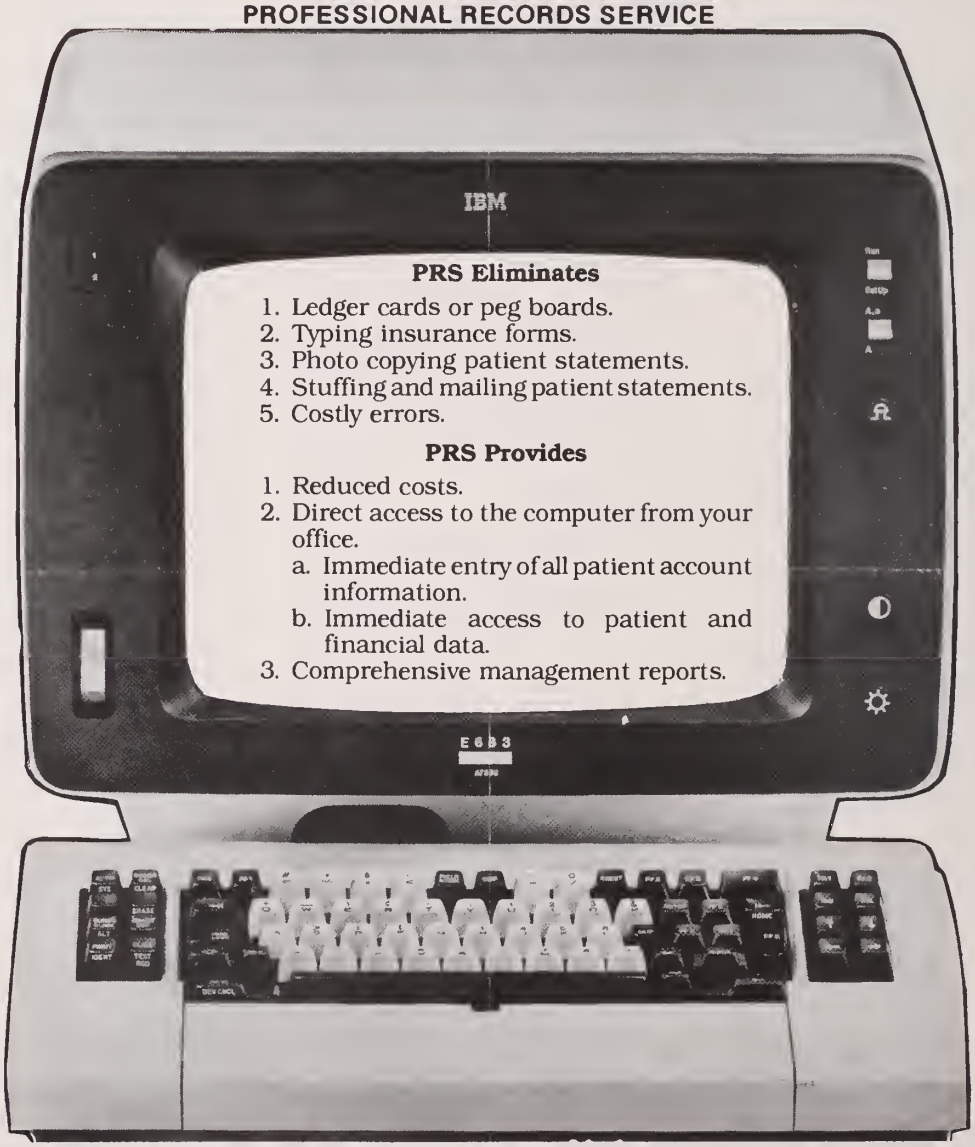

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WORKER'S COMPENSATION AND THE PHYSICIAN

MOST WISCONSIN PHYSICIANS become involved with treatment of patients covered by Worker's Compensation, which provides payment of compensation for disability, and for medical expenses necessary because of injury or illness arising out of employment.

The State Medical Society's Committee on Occupational Health, which maintains liaison with the Worker's Compensation Division, offers the following helpful information:

Filing reports. Filing reports is a direct responsibility of any physician who treats patients under the Worker's Compensation Program. WC-16 Medical Report on Industrial Injury is to be completed on a work-related injury or illness when the disability exceeds three weeks or when any permanent disability results therefrom. WC-16 is available from the insurance carrier or from WC Division. (The Committee on Occupational Health presently is involved in revising WC-16.) Information reported is used by the WC Division to determine the amount of compensation payable to the disabled worker.

Estimating disability. Learn to estimate disability according to standards set up by the WC Division. Other standards or schedules are fine for physicians' own information, but only the WC Division's standards are authoritative in Wisconsin (see "New Rules Established for Estimating Disabilities in Workmen's Compensation Cases" which appeared in the June 1975 BLUE BOOK, pp 43-45).

Completing reports. Complete report forms carefully and fully. Learn terminology of the statutes concerning compensable employment disability.

Submitting reports. Submit reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. An unexpected misfortune may place the employe in urgent need of compensation.

Payment for reports. Occasionally physicians request reimbursement for preparing and filing reports. The Committee on Occupational Health wishes to restate the following principles:

—Simplified reports including initial reports, progress reports, and final reports: No charge.
—WC-16 Report: No charge.
—When special reports are requested by the WC Division, or the insurance carrier requires an extensive or extra-ordinary report in lieu of a simplified report, a reasonable charge for preparation and filing is appropriate.

Don't be afraid to ask questions. Contact either the State Medical Society or Hugh Russell of the Worker's Compensation Division, 201 East Washington Ave, Box 7901, Madison, Wis 53707 (tel 608/266-1340).

WISCONSIN HEALTH SYSTEMS AGENCIES

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6	**NORTH CENTRAL AREA HEALTH PLANNING ASSOCIATION, INC (NCAHPA)** 811 North First Avenue, Room 27 Wausau, Wisconsin 54401	Michael Wood, MD, President George Snyder, Executive Director Telephone: 715/845-3107	Adams, Florence, Forest, Juneau, Langlade, Lincoln, Marathon, Oneida, Portage, Taylor, Vilas, and Wood
7	**HEALTH SYSTEMS AGENCY OF WESTERN LAKE SUPERIOR, INC** Ordean Building, Suite 202 424 W Superior Street Duluth, Minnesota 55802	Frank Snapp, President Felix Sereicikas, Executive Director Telephone: 218/727-8371	*Wisconsin Counties:* Ashland, Bayfield, Burnett, Douglas, Iron, Price, Sawyer, and Washburn *Minnesota Counties:* Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, and St. Louis ■

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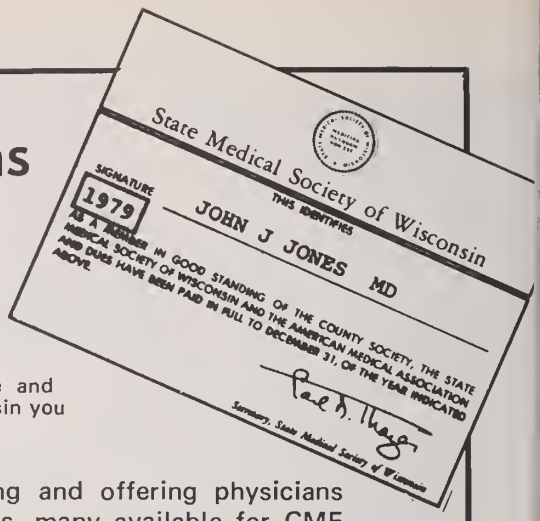

These are challenging times for any profession —times when you need the active, aggressive support of your national, state, and county medical societies to give you the professional edge you need to advance and grow. As a member of the State Medical Society of Wisconsin you receive many valuable benefits. Among them:

- **SMS Annual Meeting**—Sponsored each spring and offering physicians quality scientific and socio-economic programs, many available for CME credit.
- **Wisconsin Medical Journal and Medigram**—These publications bring you the latest in medical news affecting you and your patients.
- **Wisconsin Physicians Planning Network**—Is working to assure physician representation in the health planning process and new health services systems.
- **An Organized Lobbying Effort**—Working in Madison to ensure Wisconsin physicians have a voice in healthcare problems and issues presented to the Wisconsin Legislature.
- **Medical Assistance Agreement and Super-Rule**—The SMS Physicians Alliance is closely monitoring and negotiating the formulation of the Medical Assistance Provider Agreement and Super-Rule now mandated by state law.
- **Mediation and Peer Review**—Physicians, through a special commission, are "policing the profession" by mediating complaints of the public against physicians and where necessary imposing discipline.
- **Impaired Physician Program**—Was recently formed to help the impaired physician—the doctor suffering in some degree from alcoholism, other drug dependency, or mental illness.
- **Member Benefit Plans**—The Society offers comprehensive life, health, and liability insurance plans for physicians and their families at attractive group rates. In addition, physicians can receive practice management tips at seminars sponsored by the Society and take advantage of car rental and travel programs at special low, "member" rates.
- **Grassroots Political Action**—Developed through the SMS Physicians Alliance, local physicians meet with their legislative representatives on a regular basis to discuss issues of importance to medicine.
- **Community Health**—Society physicians are working with community organizations and individuals in providing consumer health education programs to promote a healthier Wisconsin citizenry.
- **CESF**—The Society's Charitable, Educational and Scientific Foundation, through its physician members, administers a student loan program to help students prepare for careers in healthcare; sponsors postgraduate teaching programs for physicians; and for the past two years, has participated in a Jail Health Care Accreditation Program of the American Medical Association.
- **Uniform Claim Form**—These forms, developed by the Society working with local insurance carriers, can be used by physicians in submitting claims to all private insurance companies in Wisconsin, Medicare, and Medicaid.

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Dr Harold P Rusch and the Wisconsin Clinical Cancer Center

In July Dr Harold P Rusch will become professor emeritus of the University of Wisconsin. Throughout the history of cancer medicine in Wisconsin, he has played a leading role.

Following graduation from the UW Medical School in 1933, Doctor Rusch was awarded a Bowman Fellowship to do basic research in cancer. Because of his great interest in oncology, he helped found and develop McArdle Laboratory in 1940 and served as its director from 1946-1972. His research has helped us understand the carcinogenic action of ultraviolet irradiation, the influence of diet on the development of hepatic cancer, the effect of caloric restriction on tumor formation, the stages in tumor formation, and the biochemical events that control the growth and differentiation of *Physarum polycephalum*.

In the 1950s Dr Charles Heidelberger of the McArdle Laboratory and members of the Division of Clinical Oncology developed the anti-cancer drug 5-fluorouracil (5-FU) and made it a clinically useful drug. This chemical not only was one of the first substances shown to be effective against some types of cancer but also today it remains one of the primary drugs used by chemotherapists. Ways of making 5-FU even more effective are still being studied. At about the same time the Division of Radiation Therapy of the Department of Radiology was developing into one of the country's first major resources for cancer treatment using x-rays.

National interest in cancer increased markedly at the start of the present decade. Doctor Rusch was a member of the committee which developed the National Cancer Act of 1971. Realizing that Wisconsin met the requirements of a comprehensive cancer center, the two major clinical cancer-related activities were joined to create the Wisconsin Clinical Cancer Center which NCI designated as a comprehensive cancer center in 1973. Doctor Rusch became its first director.

This unification of clinical cancer activities led to the designation of a new clinical department in the Medical School—the Department of Human Oncology, in 1975. This department is the nucleus of the WCCC. McArdle Laboratory remains a close collaborator but is a separate academic department of the Medical School, the Department of Oncology. It is devoted to certain aspects of basic cancer research.

In June 1978, Doctor Rusch retired as the director of WCCC, and Dr Paul P Carbone assumed the directorship of WCCC as well as the Department of Human Oncology. Working with him are Dr William L Caldwell† as Associate Director of the Division of Radiation Oncology, Dr Hugh L Davis, Jr, as Associate Director of Medical Oncology Affairs, Dr Kelly H Clifton as Associate Director of Laboratory Research, and Dr Robert O Johnson as Associate Director of the Division of Research and Development in Cancer Control.

The WCCC is now located in the seven-story K4 tower of the new Clinical Science Center on Highland Avenue in Madison. In addition over 100 hospital beds are available for adult oncology inpatients: 49 single rooms for acute care of clinical and radiation oncology patients, 25 for gynecology-oncology patients, and 20 for hematology-oncology patients. There is also an ambulatory care unit of 13 beds for patients who are able to go to the cafeteria for meals, make their own beds, and go to the clinics for tests and treatment, thus lowering hospitalization costs.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

† Died unexpectedly May 21, 1979.

The space devoted to cancer activities has more than doubled in amount and improved in quality in the six years that WCCC has been in existence. The number of faculty members has more than doubled. Many others are associated with the department and contribute in many ways to its program.

In addition to the oncology patients, about 40% of the surgery patients, 70 to 80% of the gynecology patients, and 25% of the pediatric patients in the hospital have cancer related illnesses. WCCC also cooperates very closely with the William S Middleton Veterans Administration Hospital, where about 250 of their cancer patients are treated each year. During the last five years the WCCC clinicians have been seeing more patients with cancers of the lung, pancreas, and liver who generally require more complex therapy.

In the 45 years since Doctor Rusch began his distinguished career, many changes have occurred in the field of oncology. The modalities of surgery and radiation therapy have been greatly enhanced. The entire modality of cancer chemotherapy has been developed. Oncologists are now able to cure 11 different types of malignant disease. About 40% of all cancer patients are now being cured. With continued research the present staffs of WCCC and McArdle Laboratory expect to cure many more cancer patients and obtain answers to other parts of the cancer puzzle.—DOROTHY J BUCHANAN-DAVIDSON, PhD, Science Writer ■

Toll-Free WATS line for members: 1-800-362-9080

As a service to its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference!

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Medical liability legislation introduced

Representative Ed McLain (D-Wausau) has introduced two bills dealing with medical liability at the request of the SMS Physicians Alliance. Assembly Bill 637 proposes that expert witnesses in medical malpractice proceedings, including formal and informal panels, must be licensed and practicing in this state or a contiguous state and must show satisfactory experience, training, and knowledge in the subject at hand. Assembly Bill 638 provides a mechanism for the use of voluntary agreements between healthcare providers and patients to submit healthcare service liability claims to binding arbitration. Assembly Bill 638 also clarifies the availability of binding arbitration as an alternative to judicial proceedings for the settlement of healthcare liability claims. Both bills have been referred to the Assembly Judiciary Committee. ■

Physicians support of clean indoor air bill urged

The SMS Commission on Governmental Affairs is urging physicians to contact their legislators in support of the "Clean Indoor Air Bill"—Senate Bill 80. The bill has now gone to the Joint Committee on Finance for review. Senate Bill 80 would regulate smoking in public conveyances and other specified places such as educational facilities, inpatient healthcare facilities, offices, indoor movie theatres, restaurants, retail establishments, and enclosed areas of a state, county, city, village, or town building. For more information on this bill, contact Don Lord at the SMS Physicians Alliance in Madison.■

Economic survey mailed to physicians

Questionnaires went out to about 1,000 randomly selected Wisconsin physicians representing 15 medical specialties last month in order to gather socioeconomic data on physicians' practice expenses and incomes. The survey, conducted by the SMS Physicians Alliance Division, will be used to compare regional data with other areas of the state and to other areas of the country. All information gathered in this study will remain confidential and will be used internally within the Physicians Alliance. All questions regarding the survey or completion of the questionnaires should be directed to Marge May at the SMS Physicians Alliance offices in Madison.■

Physicians Alliance Commission names leadership

The Physicians Alliance Commission May 18 elected Kenneth Viste Jr, MD, Oshkosh, chairman of the Commission and Jordon Frank, MD, Beloit, vice-chairman. A complete list of the Commission members appears elsewhere in this issue. ■

Legislative Guides ready for physician use

The SMS Physicians Alliance announces it has completed the 1979-80 edition of the "Legislative Guide" and that they are now available to Society physicians at no charge. The guide was developed to assist physicians in affecting the legislative process. It contains not only a directory of Wisconsin's state and federal legislators, but also an explanation of how the Physicians Alliance system of political legislative activity is executed and how physicians may effectively communicate with legislators. It will serve as a handy reference tool for physicians in the months ahead in their participation in the legislative process. For a copy contact the SMS Physicians Alliance Division in Madison; phone toll-free 1-800-362-9080, outside Madison area. ■

Legislative hotline: 1-800-362-9696

The Wisconsin Legislature has established a special, toll-free hotline to allow citizens to more easily follow the Legislature's actions and become involved in the legislative process. The Legislative Hotline can be reached from anywhere in the state by dialing 1-800-362-9696. Hotline operators are on duty from 8:30 am to 5:00 pm, Monday through Friday. Operators can provide callers with information on bill status, scheduling of committee meetings, and the agendas for the Assembly and Senate. The operators also will relay questions and requests to individual legislators or provide citizens with a legislator's phone number and address. ■

Correction

In the April 1979 issue of the *Wisconsin Medical Journal* under the heading "Governmental Affairs" we erroneously reported that the Commission on Governmental Affairs rejected AB 107, the therapeutic marijuana bill, because "not a serious enough health problem exists in this area . . ." This information was incorrect and was in fact part of a different article on a different bill. The Governmental Affairs Commission has *not* rejected the bill. The Commission supports expanded research on therapeutic use of marijuana but believes this should be done through the existing mechanism of the State Controlled Substances Board rather than through creation of an additional program. ■

—DIANE UPTON, Communications Dept

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County Societies

MEDIA RELATIONS

The first step to effective communications

"There are countless opportunities for physicians to have input into what goes into the local newspaper or is aired over the radio or television station, if they know how to go about it," Herbert Sandmire, MD, Green Bay, told about 20 physicians and their spouses at the Tri County Medical Society meeting in Ashland May 17.

Doctor Sandmire, who is chairman of the Society's Commission on Public Information, was present at the meeting along with Diane Upton, SMS Communications Coordinator, to discuss with physicians how they could develop a media relations program and in the long run improve their visibility in the community.

Beth Jones, SMS Community Health Coordinator in the Health Services Division, informed physicians of the increased emphasis the Society has placed on community health and the potential it has for county medical society involvement.

"Local newspapers, television, and radio stations prefer to deal with local authorities whenever possible," Doctor Sandmire explained, "and they consider local physicians to be excellent resources for 'localizing' a national news story."

"All too often, however, physicians have been reluctant to speak to the press, especially without prior approval of their comments from their local county medical society. Thus, in too many instances a negative story out of HEW in Washington goes without needed comment from the local medical community, and a less than totally objective news story results."

The Tri County Medical Society recently formed a "Patient Information Committee" to explore and implement public information projects in the three-county area (Ashland, Bayfield, and Iron).

The first step for this committee, Doctor Sandmire emphasized, was to make sure local media representatives knew who these physicians were and that the physicians welcomed interviews and contacts from the local media on medical issues. Developing good working relationships with the media may result in more "positive" slants in news stories than otherwise might be expected, Doctor Sandmire said, and they might also pave the way for special health-related programs or feature stories in press in the future.

Doctor Sandmire reminds county medical societies that he along with SMS Communications Dept staff are available to present similar programs on developing effective media relations at the county medical society level upon request. For further information on scheduling a presentation at your next county medical society meeting, contact Diane Upton at SMS offices in Madison, phone toll-free 1-800-362-9080 outside the Madison area. ■

—DIANE UPTON, Communications Dept

You, too, can have a good media relations program

Medicine is in dire need of good public relations at this time when assault after assault is being made on the profession in the name of the public. Accordingly, the AMA has just come out with the third printing of its booklet, "You, Too, Can Have a Good Media Relations Program," which is beamed especially at county medical societies. Further details of this AMA program appear in this issue at page 21. ■

'Loan closet' for healthcare items

Healthcare items such as walkers, wheelchairs, canes, crutches, or hospital beds can be kept in use by donating them to a local 'loan closet.' A county nurse usually knows where the loan closet is located —it may be in the county health department office, or maintained by a veteran's group, the local fire department, the local unit of the American Cancer Society, a church, or a service club. Such donations are tax deductible, when the equipment is in sound, usable condition. ■

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Organizational SMS

Council proposes study of physician distribution

The SMS Council May 9 proposed to immediately undertake a reevaluation of the distribution and availability of physicians in Wisconsin. "The appropriate distribution of physicians and availability of their medical services is a problem the State Medical Society has an obligation to address at once and in a constructive manner," SMS President Jules Levin said.

The proposal, which was approved by the House of Delegates later in the week, calls for a joint effort of the Council, Commission on Health Planning, Committee on Rural Health, the specialty societies and medical schools to study the numbers, age, and practice patterns of physicians in the state with a concentration on primary care. A full report of the study is to be presented to the 1980 House of Delegates.

The 27-member physician group also expressed concern May 9 over the haphazard manner in which "physician shortage" areas in Wisconsin are being designated for eligibility for Health Service Corps physicians and proposed that this also receive early study. The Council felt that there are neither adequate guidelines nor community and physician involvement in determining the need for HSC physicians. The House of Delegates May 11 agreed that a study of this process in Wisconsin be undertaken with a report of its findings made to the Council and the House of Delegates.

In other action at its meetings May 9 and 12 the Council:

- Supported the medical school loan forgiveness program currently being proposed in the State Legislature, but felt it should not take any position on amounts of tuition charged by either of the state's medical schools. The House of Delegates concurred with this action.
- Said it was inappropriate for the State Medical Society to suggest limitations on medical school class size as long as there are any unmet needs in Wisconsin. The House of Delegates concurred.
- Urged the American Medical Association to study alternative methods of organizing physicians in light of increasing attacks upon medical societies and other professional associations in regard to their traditional roles in promotion of ethical standards as well as in new activities of socioeconomic studies.
- Recommended that the 1980 SMS regular dues be increased 7.8 percent, or $25, to a total of $345. The SMS House of Delegates passed the increase May 11, stating it was in accordance with a 1975 House action that dues be adjusted

Lose your license?

You could . . . if you fail to report your continuing medical education credits to the State Medical Examining Board by December 1, 1979. State law requires all licensed physicians to submit proof to the Board of 30 hours of Category I continuing medical education credit. Any physician failing to report CME credits by December 1, 1979 will not receive a license renewal notice for 1980-81.

Category I CME credits accumulated since January 1, 1977 can be reported. A receipt from the sponsoring organization indicating its name, your name, the number of hours completed, and Category I approval by either the AMA or the AOA is required. Proof of CME credits must be sent by December 1, 1979 to:

State Medical Examining Board
1400 East Washington Avenue
Madison, Wisconsin 53703

. . . or you won't have a license to practice medicine in 1980. If you have questions or concerns, call the State Medical Society Health Services Division: 608/257-6781 (Madison area) or toll-free 1-800/362-9080. ■

to reflect the inflationary effect on the Society's budget.

• Directed the Executive Committee of the Council to review and update the Society's Constitution and Bylaws with a final report and recommendations forwarded to the House of Delegates at the March 1980 Annual Meeting. The Speaker of the House of Delegates will appoint three "members at large" to participate in this study. Each county medical society is invited to submit its suggestions for revision of the Constitution and Bylaws *no later than Dec. 1, 1979.*

• Authorized creation of an enlarged commission to implement, where possible, recommendations of the Council Committee on Evaluation of the Delivery and Cost of Medical Care which were approved by the House of Delegates.

• Formed an ad hoc committee of the Council to review a report on the April 23 Conference on Women's Health Issues cosponsored by the Society and the Governor's Commission on the Status of Women. Ad hoc committee members appointed by the Council were: Pauline Jackson, MD, LaCrosse; Kathryn Bemmann, MD, Waukesha; Patricia Stuff, MD, Bonduel; Sandra Osborn, MD, Madison; and Carl Eisenberg, MD, Milwaukee.

• Merged the SMS Commission on Mediation and Professional Ethics with the SMS Commission on Peer Review. A statement of responsibilities for the new commission also was approved. (These appear elsewhere in this issue)

• Made several physician appointments and reappointments to commissions and committees of the State Medical Society. (These memberships appear elsewhere in this issue)

• Supported a legislative proposal which would allow occupational therapists to be regulated and licensed by the Medical Examining Board, and for occupational therapy assistants to be certified by the Board.

• Supported Assembly Bill 66 which would allow licensure of nurse midwives by the Board of Nursing in Wisconsin, provided that an amendment is made to the bill to allow physicians to individually determine the supervision of the nurse-midwife.

• Reelected Paul S Haskins, MD, River Falls, chairman of the Council; Timothy T Flaherty, MD, Neenah, vice-chairman; and elected Richard W Edwards, MD, Richland Center, treasurer. Eugene J Nordby, MD, A A Quisling, MD, and H Kent Tenney, MD, all of Madison, were elected assistant treasurers.

• Reelected Wayne Boulanger, MD, Milwaukee, editorial director of the *Wisconsin Medical Journal.* Philip J Dougherty, MD, Menomonee Falls; Brenton H Field Jr, MD, Milwaukee; Raymond A McCormick, MD, Green Bay; T H McDonell, MD, Waukesha; and John P Mullooly, MD, Milwaukee, were reelected editorial associates. ■

—DIANE UPTON, Communications Dept

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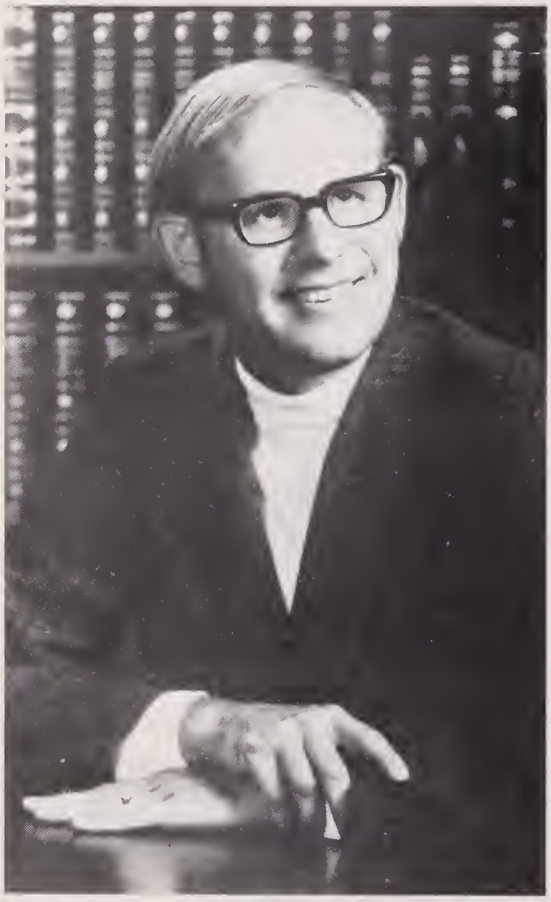

DAROLD A TREFFERT, MD, Fond du Lac psychiatrist, was installed as the 124th President of the State Medical Society of Wisconsin May 12, during the Society's Annual Meeting in Milwaukee. Doctor Treffret, 46, succeeds Jules D Levin, MD, of Milwaukee.

A native of Fond du Lac, Doctor Treffert graduated from the University of Wisconsin Medical School in 1958, later serving an internship at Sacred Heart General Hospital in Eugene, Oregon and a residency in psychiatry at University Hospitals in Madison from 1959 to 1962.

He recently resigned from his post as director of the Winnebago Mental Health Institute to head operations at the Fond du Lac County Mental Health Center, effective July 9. Doctor Treffert has served as director of the Winnebago facility since 1964. An associate clinical professor of psychiatry at the University of Wisconsin-Madison since 1965 to the present, Doctor Treffert served as president of the Wisconsin Psychiatric Association from 1974 to 1976 and was the first president to be reelected. He has served two terms as chairman of the State Medical Society's Section on Psychiatry as well as serving as a delegate to the Section on Psychiatry from 1973 to the present.

Recognized as a leading expert in alcohol and other drug abuse problems, Doctor Treffert is currently chairman of the Controlled Substances Board of Wisconsin and of the State Medical Society's Committee on Alcoholism and Other Drug Abuse. For the past several years he has been a participant in the Society's Work Week of Health program stressing positive lifestyles and illness prevention techniques for Wisconsin junior and senior high school students.

Honored as Mental Health Man of the Year by the Wisconsin Mental Health Association in 1971, he is the author of 35 publications and major papers presented at the last five American Psychiatric Association Annual Meetings; several of which have been printed in state and national scientific journals. Doctor Treffert is currently on the Editorial Board of the *Journal of Autism and Childhood Schizophrenia.* He has served as a faculty member at numerous institutes and symposia in Wisconsin and nationally and was appointed by the American Psychiatric Association as program committee member of the Hospital and Community Psychiatry Institute, a national meeting of psychiatrists and allied health professionals in mental health.

Doctor Treffert is a fellow of the American College of Psychiatrists and American Psychiatric Association and is a member of the Council of Wisconsin Psychiatric Association, the Council of American Association of Psychiatric Administrators, and of Alpha Omega Alpha.

He and his wife, Dorothy, have four children ages 22, 20, 16, 14. ■

Elections: House of Delegates, Council

The House of Delegates elected (or reelected) the following physicians to these positions:

PRESIDENT-ELECT:
Russell F Lewis, MD, Marshfield
SPEAKER: (reelected)
Albert J Motzel Jr, MD, Waukesha
VICE-SPEAKER: (reelected)
Duane W Taebel, MD, LaCrosse
AMA DELEGATES (1980-1981):
Gerald J Derus, MD, Madison
Henry F Twelmeyer, MD, Wauwatosa
AMA ALTERNATE DELEGATES (1980-1981):
Warren H Williamson, MD, Racine
John R McKenzie Jr, MD, Oshkosh

COUNCILORS:
District 1 (reelected)
Paul G LaBissoniere, MD, Wauwatosa
John P Mullooly, MD, Milwaukee
District 2 (reelected)
Allen O Tuftee, MD, Beloit
District 2 (elected)
Gerald C Kempthorne, MD, Spring Green
J D Kabler, MD, Madison
C M Hetsko, MD, Madison
District 3 (elected)
Pauline M Jackson, MD, LaCrosse
District 4 (elected)
Jung K Park, MD, Wisconsin Rapids
District 5 (reelected)
John U Peters, MD, Fond du Lac
District 6 (elected)
Irvin L Schroeder, MD, Plymouth

The Council elected (or reelected) the following physicians to these positions:

CHAIRMAN OF THE COUNCIL:
Paul S Haskins, MD, River Falls

COUNCIL VICE-CHAIRMAN:
Timothy T Flaherty, MD, Neenah

SECRETARY AND GENERAL MANAGER OF THE SOCIETY:
Earl R Thayer, Madison

TREASURER OF THE SOCIETY:
Richard W Edwards, MD, Richland Center

ASSISTANT TREASURERS:
Eugene J Nordby, MD, Madison
Abraham A Quisling, MD, Madison
H Kent Tenney, MD, Madison

WISCONSIN MEDICAL JOURNAL:
Editorial Director
Wayne J Boulanger, MD, Milwaukee

Editorial Board
Harold H Scudamore, MD, Monroe
Wayne J Boulanger, MD, Milwaukee

Editorial Associates
John P Mullooly, MD, Milwaukee
Brenton H Field, Jr, MD, Milwaukee
T H McDonell, MD, Waukesha
Philip J Dougherty, MD, Menomonee Falls
Raymond A McCormick, MD, Green Bay

A full list of appointments to commissions of the Society appears elsewhere in this BLUE BOOK issue as well as a complete listing of all Society officers and commission/committee members.■

Doctor Gundersen dies

Doctor Gunnar Gundersen, a retired surgeon and former president of the American Medical Association and the State Medical Society of Wisconsin, died May 22 at the age of 82. Memorial funds have been established for the Norwegian-American Historical Society, Northfield, Minn; Norwegian Museum, Decorah, Iowa; and the LaCrosse Foundation, LaCrosse. Further details will appear in a future issue of WMJ. ■

Dr William Caldwell dies

William L Caldwell, MD, Madison, died unexpectedly of accidental carbon monoxide poisoning May 21 while vacationing with his family in a camp located about 60 miles north of Fort Francis, Ontario, Canada. Doctor Caldwell was professor of radiology and human oncology at the University of Wisconsin-Madison Center for Health Sciences and was associate director of the Wisconsin Clinical Cancer Center. Doctor Caldwell's family has established a radiation oncology scholarship fund in his honor. Gifts may be sent to Barbara Burr in care of the Radiation Oncology Department. Further details will appear in a future issue of WMJ. ■

Dr John Wear dies

John B Wear Jr, MD, Madison, died in a plane crash (the worst in US history) May 25 at O'Hare Field in Chicago. He was chief of staff at the University of Wisconsin Hospitals and chairman of the Urology Division of the Department of Surgery. He also was a member of the State Medical Society's recently merged Commission on Mediation and Peer Review. A John B Wear Jr Memorial Fund for the University of Wisconsin Center for Health Sciences has been established, in care of the Bank of Shorewood Hills. Further details will appear in a future issue of WMJ. ■

SMS annuity unit value: $2.61

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.61 as of April 30, 1979. ■

SMS Fall Tour to Italy

A life-long dream of a trip to Italy can be a reality September 20-28 as plans for the next State Medical Society tour have now been completed.

This offering has been planned with a view not only to offer the opportunity of becoming familiar with the natural beauties and the art of Italy but also to provide a unified and distinctive impression of the country.

This will be a guided tour experiencing some of Italy's most fascinating areas with ample time for shopping and independent activities.

Italy is a composite of the ages greeting you with a maelstrom of old and new, sacred and profane. You, as well as the Romans, will pause for an aperitivo or an espresso at a crowded sidewalk cafe. You'll want to inspect Rome's 1900-year-old Colosseum, take part in a Holy Fathers Public Audience, a fashion show in Rome where high fashion artistry now threatens the supremacy of Paris. Sunday morning is the time for mercato delle pulci, Rome's weekly "flea market" at Porta Portese. Stretching for blocks along the Tiber canvas-awninged stalls offer every ware imaginable including a section where antique paintings, sculptures, books, rugs, and the like are spread over stalls and pavement. Rome, Pompeii, Sorrento, Island of Capri, and Florence are included on the tour.

Cost of this tour is $899 per person double occupancy including the following features: round trip jet air transportation Milwaukee/Rome with food and beverages. First class accommodations with private bath including tax. Continental breakfast daily with lunch and dinner in Florence. Special welcoming and farewell dinner for members of this limited group. Tour price also includes sightseeing, water transportation, and entrance fees for entire itinerary as well as all transfers, tips, and taxes. All motorcoach transportation will be air-conditioned and there will be an English-speaking courier accompanying the group throughout.

The savings are dramatic due to low-cost chartered airline transportation, group land rates, service, and other included features. And the duty free customs allowance has been raised to $300 per person. *The American dollar travels better in Italy than most of Europe.*

This tour is being planned as a SMS membership benefit through the SMS Services Inc. To assure space confirmation and for further information, members should contact SMS Services Inc, Attn: Peter Wood, PO Box 1109, Madison, Wis 53701; or phone toll-free 1-800-362-9080, outside the Madison area. ■

CONTRIBUTIONS CES FOUNDATION APRIL 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1979.

Unrestricted

The Auxiliary to The Medical Society of Milwaukee County; Waukesha County Medical Society Auxiliary; Fond du Lac County Medical Society Auxiliary; Outagamie County Medical Society Auxiliary; Grant County Medical Society Auxiliary; Ashland-Bayfield-Iron County Medical Society Auxiliary; Sheboygan County Medical Society Auxiliary; Trempealeau-Jackson-Buffalo County Medical Society Auxiliary; Kenosha County Medical Society Auxiliary; Dane County Medical Society Auxiliary—*Voluntary Contributions*

Restricted

Drs Handyside and Bates—*Externship Program*
Paul Cushman Jr, MD—*Academy of Medical History*
Elaine Locke—*General Scholarship*
Brown County Medical Society Auxiliary—*Honorarium-G Delorit (Brown County Loan Fund)*
Membership Dues; Mesdames Alan F Wentworth; Gerald B Merline; Harry H Larson; Howard J Palay; Charles F Dais—*Aesculapian Society*

Memorials

H Kent Tenney Jr, MD; Earl and Alice Thayer—*J C Griffith, MD*
Dr-Mrs Richard Edwards and Family; Mrs Frank Tuxford—*Mrs Oda Schmitt*
Mrs Stephen D Austin—*Mrs Leonard G Olsen (Brown County Loan Fund)*
Dane County Medical Society—*Clair O Vingom, MD*
Margaret Ann McCormick and Family—*Florence Thibadeau* ■

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol™ Suppositories or Ointment.

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

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How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

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Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of April 23, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/subspecialty)

County Medical Society

EAU CLAIRE-DUNN-PEPIN

Mueller, John M, 2119 Heights Dr, Eau Claire 54701 (1945, Regular, Pediatrics)
Porembski, Michael, 900 S Webster Ave, Green Bay 54301 (1945, Regular, Pediatrics)

MILWAUKEE

Arcilla, Senen S, 16525 Nancy Lane, Brookfield 53005 (1936, Regular, Anesthesiology, Certified)
Conradson, Eric P, 2712 Sussex Lane, Waukesha 53186 (1948, Resident, Internal Medicine)
Gerschke, Gary L, 2020 E Newport Ave, Milwaukee 53211 (1948, Regular, Emergency Medicine)
Hargarten, Stephen W, 2323 N Lake Dr, Milwaukee 53211 (1949, Regular, Emergency Medicine)
Keelan Jr, Michael H, 8700 W Wisconsin Ave, Milwaukee 53226 (1935, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)
Lawson, Thomas L, 8700 W Wisconsin Ave, Milwaukee 53226 (1940, Regular, Radiology, Certified)
Levin, Barry K, 1100 W Wells, #1205, Milwaukee 53233 (1951, Resident, Internal Medicine)
Uy, Benedicto P, 2315 N Lake Dr, Suite 1005, Milwaukee 53211 (1940, Regular, Hematology)
Williams, James D, 8923 N 70th St, Milwaukee 53233 (1948, Resident, Urology)

ONEIDA-VILAS

Johnson, Daniel L, Rte #1, Box 705, Rhinelander 54501 (1946, Regular, Internal Medicine/Family Physician, Certified-IM)

WAUKESHA

Morgan, Claud E, 900 Lynne Ct, Waukesha 53186 (1944, Regular, Emergency Medicine)
Wagner, Richard O, 2020 Church St, Wauwatosa 53213 (1949, Regular, Radiology)

WINNEBAGO

Grandone, John T, 411 Lincoln St, Neenah 54956 (1947, Regular, Rheumatology/Internal Medicine, Certified-IM)
Kelley, Thomas J, 105 Washington Ave, Oshkosh 54901 (1924, Regular, Psychiatry, Certified)
Mounts, Barbara M, 130 Second St, Neenah 54956 (1918, Regular, Psychiatry)

WOOD

Jones, James K, 400 Dewey St, Wisconsin Rapids 54494 (1940, Regular, Otorhinolaryngology, Certified-OPH)
Supanwanid, Preecha, 1000 N Oak Ave, Marshfield 54449 (1946, Regular, General Surgery/Plastic Surgery)

CHANGE OF ADDRESS

(Does not include those within a city)

BARRON-WASHBURN-BURNETT

Beehner, Michael L, Rice Lake, to North Willmington Rd, Lake Placid, NY 12946

BROWN

Hinz, William M, Green Bay, to 2616 Shuman Ave, Pensacola, FL 32507
Mardorf, Allen J, Green Bay, to 55 Brunswick St, Apt 2, Rochester, NY 14607

CLARK

Delorme, Robert W, Neillsville, to 21 Hamilton St, Hamilton, NY 13346

DANE

Katz, Jonathan D, Madison, to 9820 Lyndale Ave, South, Bloomington, MN 55420

EAU CLAIRE-DUNN-PEPIN

Cameron, William G, North Fort Myers, FL, to 5575 North Shore Dr, Eau Claire 54701

KENOSHA

Kleinpell, Walter C, Sarasota, FL, to 7711 Sixth Ave, Kenosha 53140
Welsch, Raymond G, Dunedin, FL, to 7728 Second Ave, Kenosha 53140

MARATHON

Prehn, Fred C, Naples, FL, to 3115 Seventh St, Wausau 54401

MARINETTE-FLORENCE

Rogers, Raymond J, Lake Park, FL, to Rte 1, Box 49, Oconto 54153

MILWAUKEE

Ackerman, Eugene J, Mequon, to 200 NE 14th Ave, Hollandale, FL 33009
Sengpiel, Gene W, Brookfield, to Rte 1, Box 120B, Woodruff 54568

PORTAGE

Walden, Richard T, Stevens Point, to 3043 North Park Dr, Lincoln City, OR 97367

ROCK

Farnsworth, R W, Pompano Beach, FL, 1324 East Racine St, Janesville 53545

SHAWANO

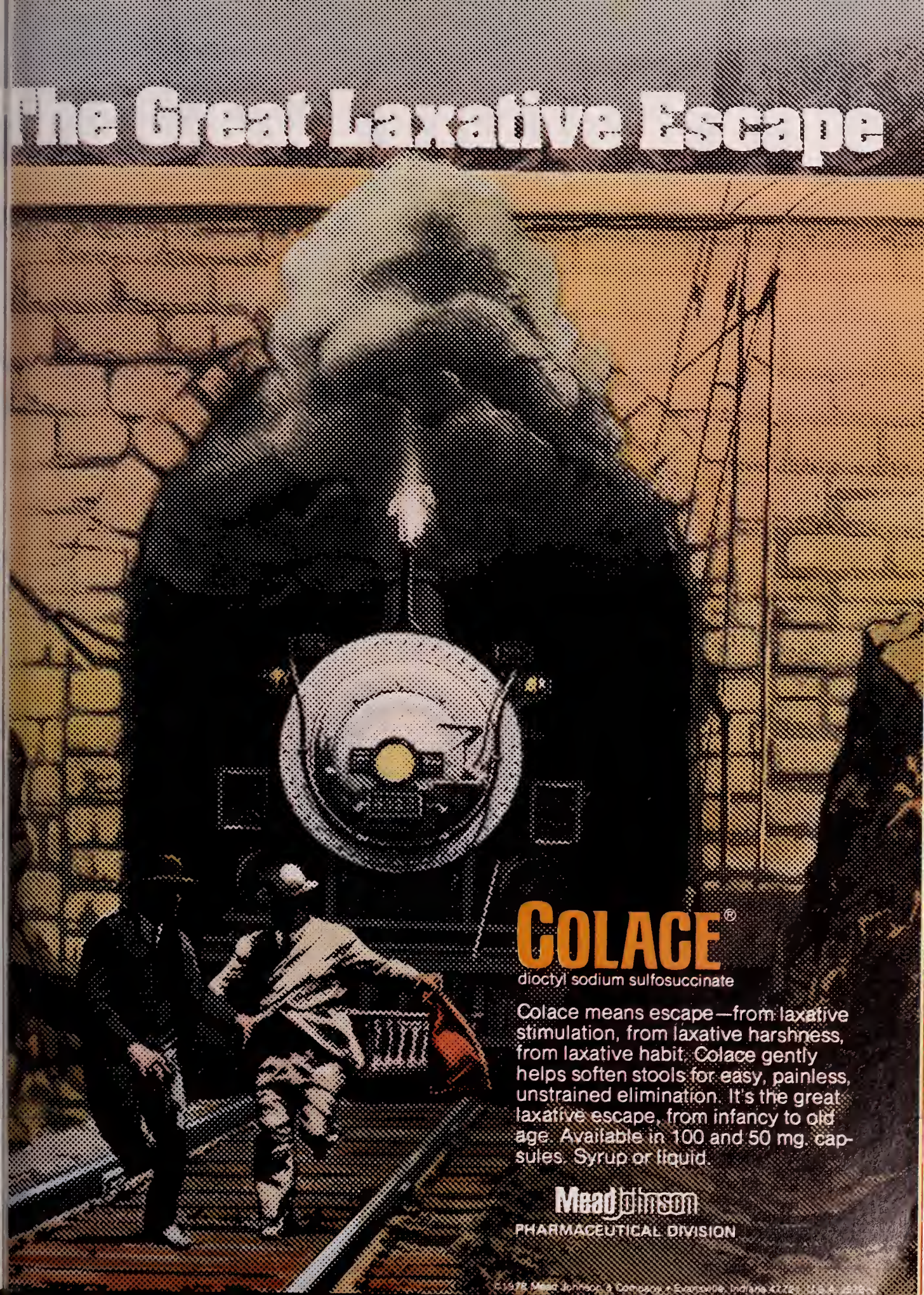
Heyl, Peter S, Newfields, NH, to 28 Roundwood Rd, Newton Upper Falls, Boston, MA 02164

WINNEBAGO

Duvall, Joseph M, Neenah, to 711 Best Brook Rd, St Louis, MO 63122

DEATHS

Wolter, Serenus H, Milwaukee County, Mar 23, 1979
Long, Chester W, Milwaukee County, Apr 8, 1979 ■


The Great Laxative Escape
COLACE®
dioctyl sodium sulfosuccinate
Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.
Mead Johnson
PHARMACEUTICAL DIVISION

COMPATIBILITY

Eastern Tiger Swallowtail Butterfly
(Papilio glaucus)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan—compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan—compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan—compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

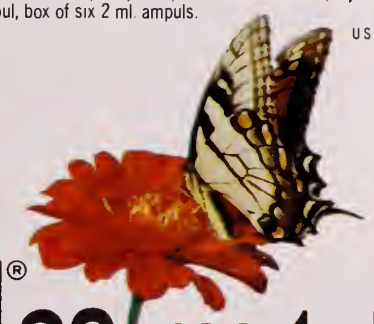
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

Mead Johnson
PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoonful (15 ml) liquid contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 9.1 mg

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100. Liquid in bottles of 1 pint and 1 gallon

See package insert for complete prescribing information.

Mead Johnson

PHARMACEUTICAL DIVISION

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Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 30¢ per word, with a minimum charge of $12.00 per ad. BOXED AD RATES: $15.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

Physicians Exchange

IMMEDIATE VACANCY FOR staff physician at Wisconsin Veterans Home, King, Wisconsin 54946. Institutional geriatric practice of 700 patients. Located in an excellent summer and winter recreational area, the Wisconsin Veterans Home offers a challenging medical opportunity with the added benefits associated with small community living. We offer a competitive salary, liberal fringe benefit program, regular hours, paid malpractice insurance and other benefits. Please contact: John Peters, Personnel Manager. "An equal opportunity employer, operating under an affirmative action program." 5-6/79

THE WAUSAU MEDICAL CENter, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology
- Dermatology
- Family Practice for satellite clinic
- Neurology
- Orthopedics
- Otolaryngology
- Radiology
- Thoracic Surgery with Peripheral-Vascular Surgery

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, write John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 3tfn/79

WANTED: TWO FAMILY PHYsicians preferably ABFP for association with the Family Medical Center, Sheboygan, Wisconsin. Please call or write: Martin A Rammer, MD, 1930 N 8th St, Sheboygan, Wis 53081; phone 414-457-5016. 5tfn/78

OB-GYN: IMMEDIATE OPENing with 9-man, multispecialty group. To join present Ob-Gyn, four internists, two pediatricians, and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing—pension plan. Young group. Contact James L Algiers, MD or Clinic Manager, Parkview Medical Associates, Ltd, 1004 East Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/79

MULTISPECIALTY GROUP OF 29 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Dermatologist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

GENERAL INTERNIST AND family practitioner to join multispecialty group of nine physicians, in suburban community, 20 minutes from Milwaukee. First year salary open, opportunity for corporate membership after one year. Fringe benefits include: malpractice insurance, profit sharing, medical reimbursement plan, life insurance, disability benefits, and more. Contact George V Murphy, MD, South Milwaukee Clinic, 100 15th Ave, South Milwaukee, Wis 53172. 6-7/79

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

PHYSICIANS—WE SAVE YOU TIME AND KEEP YOUR CAREER LOCATION SEARCH COMPLETELY CONFIDENTIAL

We're all medical professionals ourselves so we recognize outstanding opportunities. Tell us your geographic and position choices and salary expectations. We'll match them with the career opportunities we have available in Wisconsin as well as nationwide.

Contact Donna Herschleb, RN
HORNER MEDICAL PLACEMENTS
802 W Broadway, Suite L-6M
Madison, WI 53713
Tel: 608/222-1616
Licensed Employment Agency
1tfn/79

Physicians Exchange

continued

WANTED: FAMILY PRACTICE physician to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

FAMILY OR GENERAL PRACtitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

MANITOWOC CLINIC, SC IS seeking OB-GYN and pediatric specialists to join an established successful practice with 16-man multispecialty group. Excellent group benefits; retirement plan; modern clinic facilities; community has excellent educational system including two colleges; area population 80,000; outstanding recreational facilities; must be Board certified or eligible. Contact: Administrator, Manitowoc Clinic, SC, 601 Reed Ave, Manitowoc, Wis 54220. 5-12/79,1/80

GENERAL INTERNIST WITH GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info: J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

FAMILY PRACTITIONERS OR internist and pediatrician for satellite primary care office located in West Allis, Wis. Call shared by other members of 34-physician multispecialty group. For further information contact E Daun, Administrator, Northpoint Medical Group, 2388 N Lake Dr, Milwaukee, Wis 53211. Tel: 414/289-3918. 4tfn/79

EXPERIENCED GENERAL surgeon needed to join two general internists, a gastroenterologist, four family practitioners, and a pediatrician in a busy satellite of the Marshfield Clinic at Ladysmith, Wisconsin. Complete details and personal interview will be arranged for qualified applicants. Send curriculum vitae, bibliography, and three references to William M Toyama, MD, Department of Surgery, Marshfield Clinic, 1000 N Oak Ave, Marshfield, Wis 54449. 6-7/79

WANTED MEDICAL SPECIALties — small town between Milwaukee and Chicago serving a shopping area population of 50,000. Has 140-bed hospital, 14 GPs, 3 OB/GYNs, 1 ophthalmologist and 1 orthopedic surgeon. Custom built office space in superbly located new building. For full details contact Arthur L McCourt, 148 S Pine St, Burlington, Wis 53105. Tel: 414/763-7697. 4-9/79

RADIOLOGIST — BOARD CERtified is needed to become the fifth associate in an active radiology practice. One or two years experience desirable. Call 715/842-0624, or write W Mahony, MD, Radiology Associates of Wausau, SC, 425 Pine Ridge Blvd, Wausau, Wis 54401. 6tfn/79

EMERGENCY PHYSICIAN wanted to join a quality multispecialty clinic. Competitive salary plus generous fringe benefits. Recreational region. Contact Dr Mark Gibson, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449. 6-8/79

PEDIATRICIAN: IF YOU ARE establishing your new practice or relocating your old one, we are a completely equipped clinic with laboratory and x-ray facilities located near the expressway in Milwaukee suburb. Contact Mrs Harfmann at 414/771-0500. 6/79

FAMILY PHYSICIAN: APPLEton, Wis, to join four certified ABFP physicians. City of 60,000—economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact: K E Buchanan, MD, 620 E Longview, Appleton, Wis 54911. Tel: 414/734-7144. 6-8/79

OFFICE SPACE AVAILABLE
Goldsmith Building

East Wisconsin Ave. & Jefferson St.
Milwaukee, Wisconsin 53202

Charming Eight Story Atrium Building
Affordable Rents Planned Improvements
New Owner & Management

414/277-0415

Winmar of Wisconsin, Inc.

A SAFECO Company

Medical Facilities

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

MEDICAL CLINIC SPACE available. Janesville Road and Pioneer Drive, Muskego. 2,500 sq ft on ground floor. Modern, move-in condition. Please contact: Roger Bothe, John Herschede & Associates, Inc. Tel: 414/933-0585. 7tfn/78

1875 SQUARE FEET MEDICAL and/or dental office space available near downtown Sheboygan, Wis, in physician-occupied building. Contact Dept 466 in care of the Journal. 5-7/79

WANTED: USED X-RAY EQUIPment, accessories, ultrasonic and diathermy equipment. Call 414/444-7125. 5tfn/79

IMMEDIATELY AVAILABLE: 28 year general practice. Office building, equipment and office personnel awaiting new medical practitioner. Hospital and nursing homes in town. Immediate area population, 15,000. Opportunity unlimited. Contact P W Murphy, MD, Bloomer, Wis 54724. p6/79

FOR SALE: MEDICAL EXAMIning table in wood cabinet, autoclave and sterilizer in metal cabinet, diathermy in metal cabinet. Best offer. Phone 414/723-3202. g6tfn/79

FOR SALE: 50 YEAR EENT—90% eye practice. Southside Milwaukee suburb. Physician retiring. 921½ Milwaukee Ave, South Milwaukee, Wis 53172 or call 414/762-3730. 6tfn/79

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOND DU LAC FACILITY. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

NEW PRESTIGIOUS OFFICE building in Glendale. Easily accessible location, Green Bay Avenue near Good Hope Road. Good parking plan, access to building and interior circulation including elevator. Office suites can be planned for individual requirements. Call 414/961-1196. 6-8/79

FOR SALE: MATTERN PORTable x-ray, 75 milliamps. Excellent condition. Phone 414/723-3202. g6tfn/79

FOR SALE: ULTRASONIC therapy unit. Burdick model UT-1, No v-101-Serial 1965, watts 20 per square cm. Contact Mrs Long, 2435 W Greenwood Rd, Glendale, Wis 53209. g6tfn/79

Allied Health Services

POSITION WANTED: PHYSIcian assistant. August 1979 graduate of Duke University PA program. Thirty-two year old married male seeking return to Wisconsin and interested in family practice setting. Available mid-August 1979. Contact: John O'Brien, Flint Ridge #65, Hillsborough, NC 27278. Tel: 919/732-4022 (evenings). p6-8/79

Publications

MEDIC ALERT publishes *Hidden Medical Condition Index*. An index to and prevalence of hidden medical diseases and conditions in the United States has been published by Medic Alert Foundation International in Turlock, California.

The first publication of its kind, the new booklet indexes twenty-seven categories of hidden medical conditions, ranging from endrocrine, nutritional and metabolic diseases through diseases of the blood and bloodforming organs, and including diseases of the nervous system and sense organs and diseases of the circulatory system.

The index is classified according to the Eighth Revision, International Classification of Diseases, United States Public Health Service Publication No. 1693. It was prepared by a special hidden medical condition prevalence study committee of the Medic Alert Foundation International Board of Directors.

Medic Alert Foundation International is a nonprofit, charitable, and tax-exempt organization that provides a unique system of medical identification. Its purpose is to provide fast, accurate information to assist in the diagnosing and treating of individuals with hidden medical problems in emergency medical situations.

Serious allergies, diabetes, and epilepsy are a few of the many diseases or conditions why people become members of Medic Alert. When a member cannot communicate his or her problem in an emergency because of unconsciousness, or any other reason, the Medic Alert emblem speaks for that person. It helps to prevent tragic or even fatal mistakes that can be made in emergency treatment if the patient has a hidden medical problem. It is equally valuable in assisting emergency personnel to deliver effective medical treatment.

Copies of the new publication entitled "Why Medic Alert?—Index and Prevalence of Hidden Medical Diseases or Problems" are available from Medic Alert Foundation International, PO Box 1009, Turlock, California 95380.

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1979 Others

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Subcommittee on Practice Management in conjunction with the Iowa Chapter. Program carries 11 1/2 hours of Prescribed AAFP continuing education credits. Registration fee for physicians, office managers, and aides is $100. Further info: Chet Watts, AAFP Dept of Registration and Housing, 1740 West 92nd St, Kansas City, MO 64114, or call him at 1-800-821-2512.

Oct 1-5: *First International Congress of Institutional Clinical Pathology* in Mexico City. The WMJ office has details.

Oct 8-11: American Academy of Family Physicians Scientific Assembly, Atlanta, Ga.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1979-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1979 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

Nov 1-4: National Perinatal Association Meeting, St Louis, Mo. Contact: Convention Director, National Perinatal Association, 200 East Chestnut St, Louisville, Ky 40202. g9/78

1979 AMA

July 22-26: AMA House of Delegates sessions, in Chicago. (The annual convention of 1978 was the last to combine a meeting of the House of Delegates and the Scientific Program.)

Sept 27-30: AMA "theme meeting" on "Therapeutics." In Kansas City, Mo. Includes variety of other postgraduate courses.

Oct. 12-13: *Medical Staff Leadership Seminar (Advanced)*, Resorts International Hotel, Atlantic City, New Jersey. Program outline: 1) Refinements of medical staff organization. 2) Health planning and other external constraints. 3) Alternate methods of quality assurance. 4) Maximizing leadership positions: management and leader techniques. Registration fee: $200 for AMA members, $300 for nonmembers. CME credit: 14 hours in Category 1 for PRA-AMA. Further info: Call (312) 751-6657 or write to the AMA Dept of Hospitals & Health Facilities, 535 North Dearborn St, Chicago, Ill 60610.

ASPEN MUSHROOM CONFERENCE. Identification of edible, poisonous and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and advanced courses. AMA Category 1. July 29-Aug 3, 1979. Wildwood Inn, Snowmass-at-Aspen, CO. Contact: Beth Israel Hospital, 1601 Lowell Blvd, Denver, CO 80204. Tel: 303/825-2190, ext 550. 5-6/79

Nov 9-10: *Patient Safety/Risk Control Seminar.* The Breakers, Palm Beach, Florida. Course outline: 1) Recent developments in malpractice legislation and litigation; impact on medical care. 2) Professional liability insurance. 3) Physician participation in quality assurance and patient safety programs. 4) Responsibilities of the medical staff, governing board, and administration. 5) Delineation of privileges for physicians and nonphysician professionals. 6) The medical staff's potential liability for others. 7) A plaintiff's attorney looks at medical risks. 8) A defense attorney looks at medical risks. 9) The importance of medical staff influence in public and patient relations. 10) Patient complaints: frustration or medical error?. Registration fee: $200 for AMA members, $300 for nonmembers. CME credit: 14 hours in Category 1 for PRA-AMA. Further info: AMA Dept of Hospitals & Health Facilities, 535 North Dearborn St, Chicago, Ill 60610; or call (312) 751-6657.

AMERICAN PHYSICIANS ART ASSOCIATION

Are you an artist?

Are you an artist as well as a physician? And if so, did you know there is an annual art exhibit, of national calibre, strictly for doctors who are artists? It's the American Physician's Art Association, an organization now in its 42nd year. This year it will meet with The Southern Medical Association and present its yearly exhibit. The APAA has nearly 500 members across the country. In 1979 the SMA meets in Las Vegas, Nevada from November 4-7.

All physicians who work in the fields of painting, sculpture, photography, graphic arts, design and creative crafts are encouraged to join the APAA to submit entries for the November exhibit. The annual exhibit is always of top rank quality with professional arranging and hanging of the art works. Qualified judges each year award prizes in the following categories:

Oil and acrylics (classical and modern), water color, sculpture, arts and crafts, photography, and graphics. Each category has a first, second and third prize. In addition, special masters awards, honorable mention, and best of show are also given. There is consideration for advanced and beginning artists.

Membership is open to all physicians. Southern Medical Association membership is not required. Those interested write to:

Milton S Good, MD, Treasurer, APAA
610 Highlawn Avenue
Elizabethtown, Pa 17022

Apr 10-23: AMA "theme meeting" on "Cardiovascular Disease." In Los Angeles. Includes variety of other postgraduate courses.

1980 AMA

Jan 12-15: AMA Winter Scientific Meeting in San Antonio, Texas. Postgraduate courses, symposia, exhibits, and other events will be presented. (The annual convention of 1978 was the last to combine a meeting of the House of Delegates and the Scientific Program.)

STARTING YOUR PRACTICE

Workshops at AMA, Chicago

Dates: June 13-14
June 20-21
July 10-11
August 22-23
September 26-27
October 24-25

If you are a resident or physician in your first year of practice, you may be unprepared to manage the business side of your practice. The American Medical Association has developed the "Starting Your Practice" workshops to provide invaluable answers to your practice management questions.

As a participant you will be provided with a 150-page, three-ring binder workbook designed to supplement the material presented in the workshop. The workbook can later be used as an office operations manual. Additional booklets and brochures on practice management, facility planning, medicolegal forms, group practice, and other subjects are included in the material packet.

Workshop is limited to 25 participants giving opportunity to discuss and ask questions about individual situations. Spouses are invited to attend as nonparticipating auditors—at no extra charge.

Sessions are held at AMA Headquarters in Chicago.

Fees are $95 for members of county, state or AMA; and $125 for nonmembers.

For reservations, or more information, write: The AMA, Dept of Practice Management, 535 North Dearborn, Chicago, Ill 60610, or call: 312/751-6381.

18th ANNUAL MEDICAL-LEGAL-INDUSTRIAL SYMPOSIUM

Friday, November 9, 1979

Hotel Pfister/7th Floor
Milwaukee, Wisconsin

Cancer and Industry

Program

am

8:00 Registration

9:00 Welcome / Daniel A Kane, Executive Vice-President, Mount Sinai Medical Center

9:05 Introduction/Sidney K Wynn, MD, Symposium Chairman, Mount Sinai Medical Center

9:10 The Politics of Cancer/ Samuel S Epstein, MD, Professor of Occupation and Environmental Medicine, School of Public Health, University of Illinois

10:35 Cancer of the Lung as Related to Industry/ Norbert Enzer, MD

11:05 Surveillance Studies in Industry/Sidney Shindell, MD,LLB, Professor and Chairman Department of Preventive Medicine, MCOW

11:30 Metals Intoxication as Related to Cancer/Carl Zenz, MD, School of Occupational Medicine

pm

1:30 Role of RN in Early Detection of Cancer/ Judy Hayes Bernhardt, Associate Professor of Occupational Health Nursing, School of Nursing, University of Wisconsin-Milwaukee

1:50 Compensability of Occupational Cancer/Attorneys Leonard S Zubrensky and John H Jones; and Hugh Russell, Workers Compensation Division

2:50 Question and Answer Period

Further information contact Mount Sinai Medical Center, Medical Center Relations, PO Box 342, Milwaukee, Wisconsin 53201.

64th Annual International Scientific Assembly

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION

Nov 5-8, 1979—New Orleans

Designed for primary care physicians practicing in the United States and Canada. Program planned cooperatively with the Louisiana Academy of Family Physicians, Tulane University, and Louisiana State University.

Acceptable for 24 prescribed hours and 4 elective hours of credit by the American Academy of Family Physicians and the College of Family Physicians of Canada. Acceptable for a like number of credit hours toward the AMA Physician's Recognition Award.

Program consists of lectures, informal group discussions, live television, and medical movies on a variety of topics. Major emphasis in 1979 is on infectious diseases, chronic pain, nutrition, gastroenterology, endocrinology, and cardiology.

Guest lecturers include: Dr Stefan S Fajans, University of Michigan, and Dr. Harvey C Knowles Jr, University of Cincinnati, discussing "Insulin vs Oral Hypoglycemics in Treatment of Diabetes," Dr. Fredrick J Stare of Harvard University on "Nutrition—Sense and Nonsense," and Dr J Kenneth Saer, team physician for the New Orleans Saints, on "Sports Medicine." Featured speaker at the annual banquet will be Dr Robert S Eliot of the University of Nebraska on "The Management of 20th Century Stress by Physicians and Their Families." The lengthy list of speakers will include many from Tulane and Louisiana State universities and the Ochsner Clinic.

The Assembly is open to any physician in the United States and Canada. The advance registration fee is $90 ($100 at the meeting). The fee for resident physicians and ancillary health professionals is $35.

For program and registration materials, write to Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.

News You Can Use

Blue Shield raises doctor fee ceiling. Surgical Care—Blue Shield announced May 22 that it will lift its 5 percent limit on the amount physicians can raise their fees and instead allow physicians to increase their fees by an additional 1.5 percent, or 6.5 percent total for 1979. The 5 percent ceiling was announced last year by Blue Shield as a cost containment measure to fight inflation. However, in announcing the increase May 22, Blue Shield President Thomas Girard admitted that the effort hasn't been successful in holding down inflation. The ceiling involves the highest fee that Blue Shield will pay physicians for medical, surgical, and diagnostic professional services that it covers. It does not, however, preclude the physician from charging more if the physician informs the patient and the patient accepts the service.

Doctor Treffert questions Nader report. Calling it "too broad" SMS President Darold Treffert, MD, Fond du Lac, last month criticized results of a recent report by Ralph Nader's Health Research Group that cited Wisconsin and seven other states for wasting millions of Medicaid dollars on ineffective and inferior drugs. "Trying to assess the therapeutic effectiveness of a drug is a difficult art," Doctor Treffert said. He said that some drugs are truly effective medically and some may be of limited effectiveness medically but have a beneficial effect on patients psychologically. The real concern, Doctor Treffert said, should center on careful measuring of the risks *vs* benefits of medication—as Wisconsin did when it prohibited doctors from prescribing amphetamines for weight control alone. In addition, the State Dept of Health and Social Services is formulating plans to develop profiles of patients who seem to be getting an excessive amount of medication, he said. Doctor Treffert thought that these efforts represent a more sensible approach to preventing drug abuse than putting a ban on individual substances.

Procedures detailed for Patient Compensation Panel referrals. In late April 1979 the State Medical Examining Board moved to promulgate Chapter Med 12.03 (2) of the Wisconsin Administrative Code which outlines procedures the Board will use in handling referrals from the Patient Compensation Panels. Under Section 655.08, Wis Stats, whenever a Patient Compensation Panel finds that a physician has acted negligently and such negligence has caused injury or death to a patient, the Panel is obligated to inform the Medical Examining Board of the facts of the case and it in turn is to determine whether the physician is also guilty of "unprofessional conduct." If the latter finding is made, the Board may invoke any one of a series of sanctions including revocation of license. The Board recently has testified to a joint Senate/Assembly committee that negligence and unprofessional conduct "are not necessarily the same nor are they mutually exclusive. A negligent act of a doctor might be one example of his course of unprofessional conduct. However, a competent doctor might have made a one-time mistake and thus been found to have acted negligently by the Patient Compensation Panel. If there were minimal potential for harm to the public, that would probably not be unprofessional conduct." Public hearings on proposed Med 12.03 were held in late April and it has now been forwarded to the Assembly Judiciary Committee and the Senate Human Services Committee for review.

FTC investigating possible violations of 'eyeglass rule'. The Federal Trade Commission has launched an investigation to determine whether ophthalmologists and optometrists are violating the Commission's "Eyeglass Rule," which requires them to provide each patient with a written prescription immediately following an examination. The Rule also prohibits restrictions on advertising of eye examinations or prescription eyewear. The investigation also will determine whether this Rule provision is being violated. FTC staff attorney Scott Klurfield, who has primary responsibility for enforcing the Rule, reports, "from some parts of the country we have received only isolated complaints, but in other areas, it appears that a substantial number of practitioners are disobeying the Rule." ■

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WISCONSIN MEDICAL JOURNAL

JULY 1979

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- Aging and surgical risk in older citizens of Wisconsin
- IN PERSPECTIVE: "Who's on first . . .?"
- Patients compensation panel crisis

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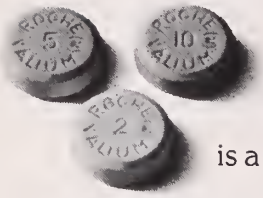

Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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Front Page Update

Patient Compensation Panel cases on the increase. Director of Patient Compensation Panels Jeffrey Kravat reports that the number of malpractice cases filed with the Panels during the first five months of 1979 is equal to the number filed during all of 1978. Presently, about one case a day is filed with the Panels and this is expected to increase during the coming months. Kravat explains that this increase is due to: (1) Many lawyers delaying filing malpractice suits until the constitutionality of the panel process was upheld by the State Supreme Court; and (2) All alleged malpractice incidents occurring after July 1975 must be filed first with the Panels and not the circuit courts. Many of these cases are now coming into the panel process. (See also editorial, "Patients Compensation Panel Crisis," in this issue.)

Dates are set for Family Physician seminars. The "One Day Seminars for Family Physicians" in Green Bay will be held this year on September 9 at St Vincent Hospital; October 17 at Bellin Memorial Hospital, and November 14 at St Vincent Hospital. Brochures describing the program content for these outstanding seminars sponsored each year by the SMS Commission on Continuing Medical Education and the Fox Valley Chapter of the Wisconsin Academy of Family Physicians will be mailed to physicians in early August.

Chiropractors lobby for amendment in SB 30. After the Joint Finance Committee of the Legislature voted 8-5 to recommend "indefinite postponement" of Senate Bill 30, the mandatory chiropractic coverage bill, the Wisconsin Chiropractic Association has been attempting to get the bill amended to include an "opt-out" clause. Under the proposed amendment, an individual would "opt-out" of chiropractic coverage by informing the insurer of his or her desire to use chiropractic services. The State Medical Society opposes this amendment because it would still mandate all insurers to cover chiropractic services. In addition, present law already requires that insurers who offer health insurance policies which cover either physicians' or chiropractors' services must also *offer* to include coverage for *both* physicians' and chiropractors' services. The patient then decides whether to pay for the coverage. Due to delays in the State Budget approval process and the Chiropractic Association trying to amend SB 30, the chiropractic coverage is not expected to reach the floor of the Legislature until next October.

Doctor Treffert urges support for wellness program. SMS President Darold Treffert, MD, Fond du Lac, appealed to members of the Wisconsin Assembly June 14 to retain a $980,000 allocation for the Prevention and Wellness Grant Program in the bienniel budget bill. The Assembly June 13 voted 51-46 not to reject an amendment which called for eliminating the wellness grant program from the budget. "The wellness grant program is one of the few bright spots in this State's efforts to improve health and prevent illness while at the same time trying to contain costs," Doctor Treffert said. "No one believes it is a panacea. But there are too few efforts aimed at local community and public involvement in keeping people well. "The investment of a fraction of 1% of our budget seems well worth it," he said. Doctor Treffert explained that the State Medical Society has supported this kind of health promotion effort for several years and urged the Assembly to invest in its opportunities.

Wisconsinites awarded Medical Explorer citations. A Medical Explorer and an Explorer Post from Wisconsin were honored at the American Medical Association's Annual Meeting July 22 in Chicago. Karen Middleton of Madison and the Manitowoc County Search and Rescue Unit, Explorer Post #2911, received awards presented by the AMA in cooperation with the National Association of Medical Exploring and the Exploring Division of the Boy Scouts of America. The awards are based on contributions to the community, state, or nation in the fields of medicine, medical research, or citizenship projects related to health. ■

A reminder

ZYLOPRIM®

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- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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Created by the Territorial Legislature in 1841

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* the official publication of the Society.

Editorials

Editorial Director: WAYNE J BOULANGER, MD

Patients compensation panel crisis

MOST PHYSICIANS WHO have served on the Patients Compensation Panels have come away feeling that the system works reasonably well and deserves our continued support. It became apparent to Jeffrey Kravat, the Director of Patient Compensation Panels, as early as last summer that he was understaffed. Even though there was money available to pay additional help, none could be hired because of Acting Governor Schreiber's moratorium on hiring state employees.

The freeze is still in effect.

Attempts by the State Medical Society's Physicians Alliance to tack amendments on to the budget bill have failed in both the Senate and Assembly, and as of this date, the total staff consists of Mr Kravat and two clerks—this in spite of the ominous fact that the caseload for 1979 has already surpassed that of the entire year 1978.

Mr Kravat states that if he is to keep up with the routine work, not to mention statistical reports on settlements achieved so far, he needs two more employees. (Ironically, this is one situation where there is no shortage of money to pay additional employees, since support of the project is derived from the Patients Compensation Fund, not from tax dollars.)

If you agree that the panel system works and is worth supporting, why not make your feelings known? If backlogs become too great, and the process bogs down, detractors will soon be calling for return to the chaos of 1975, which could be a real step backward.—WJB

Precocity

THERE IS AN OLD tale about how young offspring generally regard their parents as being relatively uninformed and generally just not with it. Then with the passing years as the youngsters mature, they are amazed at how knowledgeable their parents have become.

There is a similar situation with medical students in their junior year at school. At least in the past we, as junior medical students, felt that we had reached the absolute apex of medical knowledge and were inclined to be extremely critical of our faculty members and attendings. Again, as the years went by, we became more humble and aware of our own limitations. In retrospect we realized we weren't so omniscient and became much more respectful of our superiors.

Recently a freshman medical student appeared at an Assembly hearing at the State Capitol. He was critical of the University of Wisconsin Medical School's administration and of some of the departments in the clinical years. A second year student also appeared at the hearing and was not pleased with the rotation of students through various clinical departments.

Unless there have been some innovative changes in learning and teaching, it would seem that there should be enough material in the first two preclinical years of medical school to keep a student fully occupied, without his having the temerity to express premature concern in areas to which he has not been exposed.

—VSF

Make a house call—you'll feel better

AT JUST ABOUT ALL levels of medical society structure, when physicians are polled regarding their concerns for the future of the practice of medicine, they cite the deterioration of the doctor's image as a major problem. In recognition of the gravity of that concern some medical societies have engaged public relations firms to attempt to restore some of our lost lustre.

And maybe it will help.

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Maybe, but no public relations firm can help us regain our lost stature unless we do something to help ourselves.

Actually, we've been doing just the reverse. The following true story exposes the heart of the problem:

A few months ago a highly respected internist died. He had been in practice in Wisconsin 41 years and had developed a large elderly clientele. He made a lot of house calls. He made them whenever it was the obvious thing to do without being asked and without being condescending. He was able to make working diagnoses without having to order $200 worth of corroborative laboratory and x-ray studies. Naturally his patients loved him, and many have had great difficulty finding a satisfactory replacement since his death.

One of his former patients is seeking her third new doctor in the last four months. She is 84 years old and home-bound. Although each new physician has been well qualified, each has failed to measure up because of a refusal to make house calls. Her second new doctor explained the refusal to make house calls in this manner: "If I find anything wrong, I won't be able to do anything about it in the home, anyway."

That attitude and the tendency to refer everything after routine working hours to the hospital emergency room will more than negate anything all the public relations firms in the country can do.

The disturbing thing about the extinction of the house call is that it isn't really caused by the so-called doctor shortage. The doctors cited above were young and did not have busy practices. They refused to make a sacrifice because they lacked the dedication of their older predecessor. If they practice 41 years with that same lack of dedication, they will leave practice unloved by their patients. The doctor's image will be even less shining a generation from now no matter how great is our science and how much we advertise our skills.

To say that the return of the house call would solve our image problem is to over-simplify, but it would signify to our public a willingness to make sacrifices for the good of our fellow man—something that once used to be part of being a doctor but is now a rarity in our profession.

Why not bring back the old values? Why not make a house call this week? You'll like your image better. You'll feel better. You might even become a better doctor.—WJB ■

Letters

Maternal mortality

Dr Frederick Hofmeister's article on maternal mortality (April 1979, *Wisconsin Medical Journal*) certainly reveals some interesting, worthwhile statistics. This type of study should be strongly encouraged and even further information and ideas gleaned from it. There is, however, one very disturbing sentence.

I refer to the third sentence of the first paragraph which, if I interpret it correctly, suggests that the social factors inhibiting appropriate parenting and feelings can easily be corrected simply by showing concern. Nothing could be further from the truth. The morbidity and human suffering produced by the "unwanted" (perhaps "not ready for" should substitute the commonly used "unwanted") pregnancy far out weighs the total morbidity and human suffering due to maternal death. Yet we are all too often helpless in trying to deal with this problem.

A visit to a family physician's office to observe the well-baby examinations will show a relatively large percentage of infants with lousy hygiene who neither smile nor coo very often, frequently with bald spots on the occipital area from staring at the ceiling and without the bubbly alertness an infant should have. A visit to the elementary schools would show the obvious insecurity and lack of motivation produced by that early neglect. A visit to social services, healthcare centers, juvenile courts, juvenile correction institutions, adult prisons will make very clear the unfortunate sequence that many of these children follow. Correcting the situation may be impossible, improving it will undoubtedly be expensive in both time and money but the return in the dollar and in the hours spent will certainly be greater than perfecting an already good record such as maternal mortality.

To summarize, there are a great number of children who are not receiving the love, attention and interest so necessary to healthy development. I feel that there is a great deal more of human suffering as well as being expensive to society regarding this factor than there is regarding maternal mortality. Let me reiterate that Dr. Hofmeister's article and studies are indeed excellent. But if he truly has a viewpoint that the social problems surrounding pregnancy, delivery and child raising are cured simply by counselling Dr Hofmeister must have a very narrow tunnel vision indeed. We have much more room for improvement in this area than we have in maternal mortality.

Geoffrey C Klosier, MD
Diplomate, ABFP
Merrill, Wisconsin

The Editors would like to encourage physicians to contribute to the LETTERS TO THE EDITOR section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Unified membership

I have just received the April issue of the *Wisconsin Medical Journal*. Please accept my congratulations on your (John P Mullooly, MD, Milwaukee) editorial "Unified membership: To be or not to be." It is excellently phrased and most timely.

Physicians are in all too many cases misreading or disregarding the temper of the times. The real goal of many critics of professions is not to strengthen but to deprofessionalize them. It would apparently be hoped an omnipotent state could then control the functions and the performance of former professionals who had been reduced to the status of technicians, if not robots. The nightmare possibilities of this goal and the substantial progress made toward its realization ought to keep people up nights, including thoughtful nonprofessionals.

I have detected in the several professions which our office observes and represents, two extremes of the pendulum. One is continued indifference, or that the individual can weather what the group cannot. The other extreme can be best described as near suicidal. It has long

been my view, which I have expressed to physicians as well as to others, that the professions have developed in response to fundamental, social and personal needs. They can be severely limited in their performance, and rendered impotent in expressing their full function, but they cannot be eliminated for any length of time. They come back again, even though under a somewhat changed guise. Russia offers a large scale laboratory confirmatory of that theory. The Russian leaders learned from hard experience something the US "leaders" of public opinion and an unknown portion of the public have yet to perceive or accept.

Whether professional people in general, and the medical profession in particular realizes it, the national organization of each profession, is deserving of primary credit for the retention of the substantial independence which professions continue to enjoy in this country despite an effort of more than 40 years to discredit them and to do so in the name of equality.

I am going to bring your editorial to the immediate attention of the State Bar leaders. It deserves a wider audience than that, but I shall try it out first at state levels.

ROBERT B MURPHY
Madison, Wisconsin

Labor of love

AS MY YEAR AS PRESIDENT of the Society comes to a close, may I again convey to you (Victor S Falk, MD, Medical Editor) and your Editorial Board my gratitude for the excellent caliber of our *Wisconsin Medical Journal*. I appreciate the endless hours involved in this labor of love and would merely like to say, "Hear, hear!"

JULES D LEVIN, MD
Milwaukee, Wisconsin

Discovery clause

ASSEMBLY BILL 327 has drawn opposition from the Medical Liability Committee and the Council because it adds a discovery clause to the Statute of Limitations which would permit malpractice action to be initiated up to three years after a patient becomes aware that an injury occurred.

The present statute makes no allowance for delayed discovery. It allows action to be brought within three years of the incident on behalf of adults or within three years or by age ten for minors, whichever is later.

Opposition to a discovery clause by physicians makes fiscal sense, of course, and is readily understandable, but is it fair? While we have a right to protect our interests, we deny our patients their rights if we fail to disclose the retention of a surgical sponge until after the three-year period has passed. A discovery clause would afford the injured party ample time to seek redress, should he choose to do so, after discovery of the error.

A bill which allows no grace period for discovery is totally unfair. But a three-year period seems unduly long. Why not compromise and settle for one year?

WAYNE J BOULANGER, MD
Milwaukee, Wisconsin

Immunization program

IN THE JANUARY 12, 1979 *Medigram* of the State Medical Society, volume 1, number 2, I was disappointed to see a continuation of the MacDonald Restaurant immunization program. I feel it is quite inappropriate for the State Medical Society to be a vehicle for the advertisement of the MacDonald chain. Although the purpose of encouraging immunizations is certainly worthwhile, the means to accomplish this which have been used by the Medical Society are very inappropriate. The immunization certificates are obvious advertisements for the MacDonald Restaurants. It is merely a "gimmick" to get people to frequent the MacDonald Restaurant chain. In case it has slipped your attention, the MacDonald Restaurant chain is not a public service organization, but is a private enterprise whose concern must be profit. To have the Medical Society be used as a vehicle to circulate advertisements for this private enterprise is very poor judgment. I am surprised and disappointed for the Medical Society to allow itself to be used in such a manner.

ROBERT L SCHWARZ, MD
Menomonee Falls, Wisconsin

EDITOR'S NOTE: The WMJ welcomes comments from members who wish to express their views on Society affairs such as that expressed above. While the MacDonald Restaurant involvement in the immunization program may have its negative aspects, the State Medical Society and other members of the Wisconsin Immunization Initiative Coordinating Committee feel that the overriding benefits in improved public health have much greater significance. However, physicians' concerns and viewpoints will be taken into consideration in future deliberations of the immunization program. ■

In Perspective

BRIAN JENSEN, Director
Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

"Who's on first . . . ?"

A RECENT SERIES in the Madison *Capital Times* regarding legislative lobbyists and lobby organizations brings to mind the Abbott and Costello routine of "Who's on first, What's on second," etc as various organizations scramble to identify themselves as "effective" lobby groups. I'm sure many of the organizations and lobbyists cited in the series would have preferred to remain out of the limelight. Much of the discussion surrounding the organizations cited grassroots activity and political action committees as two reasons for their effectiveness in the legislative process.

One consistent point throughout the series was the identification of several organizations as effective because of large memberships and aggressive political action efforts. However, one point ignored by the *Times* was the type of issues which the various organizations cited confront every legislative session. The Wisconsin Realtors Association, for example, was cited as one "grassroots" organization effective because of 10,000 members and a large political action committee treasury. The membership represents one-third of the approximately 38,000 realtors in the state. Chiropractors were cited as one of the most effective groups "pound for pound" in the state.

But what of the issues handled by these groups? It is no secret that nearly 20% of all legislation introduced each session (approximately 400 bills) relates in some way to health care and the practice of medicine. Chiropractors, for example, are a one or two issue group. (I might also add that they have been unsuccessful since the political "rebirth" of Wisconsin physicians in 1975.)

Physicians, on the other hand, enjoy (or suffer) the distinction of having to deal with a host of very complex issues each session, and face the difficult task of relating to legislators on issues as diverse as brain death, genetic testing, DNA research, insurance coverage, medical school class size, "super-rules," immunization laws, peer review and rules of protocol, protection of patient records, jail health care, health planning, rate review, and the list continues on and on.

Some of these issues are difficult to resolve and result in a legislative/political solution to a scientific problem; no easy task for a physician let alone a legislator. Many of these issues are not direct pocketbook issues for the physician, but rather are reviewed by physician committees and commissions from the standpoint of what is good health policy. For that, the physicians of Wisconsin are to be commended.

From the standpoint of political organization and effectiveness, it would be easy to be a one issue organization. However, physicians cannot enjoy that luxury if they are to continue to be in the forefront of the development of sound health policy. Neither does the list end with current legislative concerns. The State Medical Society has already embarked upon studies of physician distribution, the status of public health in the state, cost containment, and new ventures in the impaired physician program, peer review, and the financing mechanisms at work in the total health care system. Some of these issues may impose a certain level of constraint upon the practice of medicine; however, it will be the physician community in Wisconsin that takes the initiative, not a misguided bureaucrat or a health planner with academic training in philosophy.

The Physicians Alliance has as its cornerstone the advocacy of the physician viewpoint in these varied issues. I have been greatly impressed, however, with the Wisconsin physicians' willingness to do what is right rather than what is most expedient politically.

Today the State Medical Society works to represent about 70% of all Wisconsin physicians. By any standard that is an extremely high commitment both financially and organizationally to the work of SMS. That work is not only carried out by committees, commissions, and staff, but by physicians in the "grassroots" arena meeting with legislators and other public officials, allied healthcare personnel, and civic and community groups. That, I contend, is the mainstay of the Society—the local physician dealing at the local level with local people.

The next time you see Lou ask Bud "Who's on first?" you will know the obvious answer.

—BRIAN JENSEN ■

Special to the Journal

A Special Conference

Women's Health Issues

IN WISCONSIN, as throughout the nation, consumer concern for health and medical care is on the rise. People are expressing a much greater interest in health promotion, the cost of medical care, and their rights as patients.

The loudest voice by far is coming from women who utilize the health care system far more than men and often assume responsibility for their family's health. In response to this growing movement the State Medical Society of Wisconsin initiated a special conference on Women's Health Issues in April 1979. Its purpose was to provide common ground for consumers and providers to discuss the health issues that are special and important to women.

The conference was one of the first of its kind in the country and it attracted 427 Wisconsin women. They came from all parts of the state—urban and rural, north and south, east and west. They represented a variety of occupations. There were teachers, lawyers, housewives, secretaries, nurses, laborers, librarians, students, physicians, writers, weavers, counselors, and community health workers. Their ages ranged from 18 to over 70 years. Although they were a very diverse group of women, they had one thing in common—a serious interest in the health care system.

THE CONFERENCE

The Conference was the brainchild of a handful of women physicians who believed that not enough attention was being focused on women's health issues. After securing support from the Executive Committee of the State Medical Society Council to proceed with a "Women's Health Issues Conference," it was felt that co-sponsorship should be sought from a prominent, statewide women's organization. The Governor's Commission on the Status of Women was selected because of its excellent reputation as a strong advocate for women and the substantive work it had done on women's issues over the 15 years of its existence. Women's Education Resources and the Health Science Unit of the University of Wisconsin Extension were consulted and agreed to assist in the planning of the Conference.

Prepared by Beth Jones, Community Health Coordinator, Health Services Division, State Medical Society of Wisconsin. Staff photos by Ken Opin. Reprint requests to: Health Services Division, State Medical Society, PO Box 1109, Madison, Wis 53701. Copyright 1979 by the State Medical Society of Wisconsin.

Georgia Ignace, Milwaukee Indian Health Board, Milwaukee; *Gene Boyer,* National Organization of Women, Beaver Dam; *Ben Peckham, MD,* Professor of Gynecology-Obstetrics, University of Wisconsin Medical School, Madison; *Darold Treffert, MD,* Psychiatrist and President-elect, State Medical Society of Wisconsin, Fond du Lac; and *Nelia Olivencia,* Governor's Commission on the Status of Women, Madison.

"Everyone took the conference seriously. We'll be held accountable for those recommendations."—DAROLD TREFFERT, MD

A Conference Planning Committee was quickly established that included physicians, Governor's Commission members, and representatives from the University Extension. Kathryn Clarenbach, Chairperson of the Governor's Commission on the Status of Women and a prominent leader in the women's movement, was elected Chair of the Committee. Kathryn Bemmann, MD, a Waukesha psychiatrist, was elected Vice-chair. The Committee set four basic objectives for the Conference:

(1) To educate the participants about women's health. issues.

(2) To provide a forum where health care concerns of women could be voiced.

(3) To make recommendations to physicians for ways to make the health care system more responsive to their needs.

(4) To encourage women to participate fully in influencing health care policies.

The Committee worked over a period of six months to plan the Conference, select the major issues, and secure qualified speakers. The Conference was structured around the following seven workshops.

1. *Women's Rights and Responsibilities as Patients* which considered the issues of physician-patient communication, sensitivity to women's needs, and women's influence on health policy.
2. *Women and Surgery: What are the Choices?* which considered the issues of hysterectomy, sterilization, and breast surgery.
3. *Birth Control and Unplanned Pregnancy* which considered issues of birth control, its availability, and the options for unplanned pregnancy including termination, adoption, and keeping the child.
4. *Maintaining Health During Pregnancy and Childbirth* which considered the issues of alcohol, tobacco, and other drug use during pregnancy; genetic counseling; and alternative settings for childbirth.
5. *Health in the Middle Years and Beyond* which considered the issues of menopause, hormonal therapy, health assessment, and mental health for the older woman.
6. *Women, Alcohol and Drugs* which considered the issues of drug misconceptions, prescription drug abuse, and the availability of services for women alcoholics.
7. *Women's Mental Health* which considered the issues of defining mental health, stress, depression, and the impact of changing roles on women's mental health.

Bea Kabler, Member, Board of Directors, Planned Parenthood of Dane County, Madison; and *Anne Seiden, MD,* Chairperson and Psychiatrist, Department of Psychiatry, Cook County Hospital, Chicago, Illinois

"The service delivery system in general has been from a provider perspective rather than a female consumer perspective."—ANNE SEIDEN, MD

Each workshop was planned to stimulate thoughtful discussion on the issues. Audience participation was excellent providing for truly a grassroots expression of thought and concern on women's health issues.

Complementing the workshops were special presentations during the lunch hour by minority women who spoke eloquently and forcefully of the special health needs of Native American, Black, and Hispanic women. A keynote address was delivered by Anne Seiden, MD, Chairperson of the Department of Psychiatry at Cook County Hospital, Chicago, and Vice-chair of the National Women's Health Network. Doctor Seiden characterized the health care system as a woman's issue because women are the primary consumers of health care utilizing the health system more than men for general health care, reproductive care, and pediatric care. The problem, Doctor Seiden said, is that the health care delivery system still operates from a male provider perspective rather than a female consumer perspective.

Doctor Seiden praised the Conference as a major step forward in raising public consciousness about women's health issues. She urged the 427 participants to become involved in health policy formation and to seek positions of power in the health system and use them to benefit women. "If we can't seek it, learn it, display it, and enjoy it, we are not going to use it effectively," she said. "With power, the future of health care is ours."

THE RECOMMENDATIONS

A major attraction of the Women's Health Issues Conference was the opportunity for participants to formulate recommendations on how the health care system could better meet the needs of women and transmit them directly to Wisconsin physicians through the State Medical Society. Throughout the seven workshops, the panel of minority women, and the keynote address by Doctor Seiden, the women were encouraged to speak openly and freely of their views as to how the health care system could be improved.

Recommendations and suggestions came forth in great numbers. They were offered constructively and were addressed not only to physicians but also to other health providers and institutions.

Some of the recommendations were aimed at women themselves. Women were encouraged to ask questions of their physician, insist on full information on their diagnosis and treatment options in terms they can understand, and acknowledge that the final decision on the kind of medical treatment they receive is truly their own to make.

From speech to speech and workshop to workshop the recommendation that recurred time and again was that the physicians and other health professionals should treat women with more respect and sensitivity. Physicians should avoid stereotyping and prejudging women patients

Lynn Cullen, Newscaster, WISC-TV Channel 3, Madison; *Kathryn Bemmann, MD,* Psychiatrist and Member, Governor's Commission on the Status of Women, Waukesha; *Julia Burgess,* Milwaukee County Department of Social Services, Milwaukee; *Jules Levin, MD,* Neurosurgeon and President, State Medical Society of Wisconsin, Milwaukee; and *Kathryn Clarenbach, PhD,* Chairperson, Governor's Commission on the Status of Women, Madison

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"Because of their role in childbirth, family care, and often major careers . . . women have physical and mental health needs that constantly change and require special attention."—KATHRYN CLARENBACH, PhD

Excerpts from Conference Recommendations

FOLLOWING ARE *excerpts* from the conference recommendations. They were generated by women consumers who participated in the seven workshops. A full report can be obtained by writing to the Health Services Division of the State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701.

- Physicians should take more time to educate patients on health care and illness prevention. If adequate time is not available, physicians should employ patient educators.
- Physicians should provide women with more information on prescription drugs and their side-effects.
- Physicians should establish a grievance procedure in their offices that can be used by patients wishing to lodge formal complaints.
- Medical school curriculae should be expanded to include greater instruction on women's health. Medical students should be instructed in the sensitive treatment of women patients particularly with regard to reproductive and gynecological care.
- Every patient has the right to dignified treatment and care. Minority women, the very young and older women, lesbian women, and poor women report that they are often made to feel uncomfortable and sometimes unwelcome in medical settings. Efforts should be made to provide considerate and respectful care to these women.
- Many women now believe that not all surgery is needed, and that women are over-operated. Physicians should spell out all the options for treating the patient, even those options they don't themselves recommend. Patients should receive fact sheets on their surgery options, with pro and con entries for each option.
- Physicians should remember that sometimes mental or physical reactions to breast surgery can occur long after surgery, and it would help to anticipate this by telling patients where counsel or help can be found.
- Patients who are reticent or self-conscious should have the right to be accompanied by an advocate or friend to help them communicate with the physician and select the best treatment option.
- The State Medical Society should publish informative pamphlets on surgery, particularly on breast surgery and hysterectomy, that uses language that can be understood by the lay people.
- The medical profession should support technological research that will produce safer and more reliable contraceptives. Particular emphasis should be placed on the development of new, male contraceptives.
- Physicians should provide written information on all reproductive and gynecological care they provide in lay terms at a reading level that every person can understand.
- Regardless of a physician's own personal values, he/she should provide women confronted with an unplanned pregnancy with information that is requested on all options including adoption, medical termination, and keeping the child or refer these women to appropriate agencies for pregnancy counseling.
- More information is needed on the harm smoking, alcohol and drugs (including over-the-counter drugs) can do to potential child-bearing women. Ways in which to get this information into the high schools should be explored. Pamphlets explaining these facts could also be distributed by physicians and other medical care providers.
- The taking of any medication during pregnancy should be discussed, and a pregnant woman should only take medication from the physician providing the obstetrical care. The discomfort of not taking medication should be weighed against the risk to the fetus of taking medication.
- Physicians should respect the variety of sexual attitudes and practices of elderly women. Sex education should be available for older women.
- Physicians should support greater research on post-menopausal osteoporosis and monitor new treatment modes.
- There should be increased emphasis on the diseases and medical needs of the elderly in the medical school curriculum.
- Physicians should be knowledgeable about special treatment programs for women alcoholics so they can appropriately refer women for help.
- There should be more child care facilities available for women in alcoholic treatment programs. Foster care during treatment may imply that a woman is an unfit mother.
- Women have been excluded from most areas of defining mental health. Theories of personality are geared toward the male. Women must have input in defining mental health.
- Physicians need to be aware of the uniqueness of individual women patients and to avoid stereotyping and prejudgments such as assumptions of neuroticism, hysteria, and non-adaptiveness.
- Physicians should refrain from over-utilization of tranquilizing drugs for women patients. "Pills" shouldn't be thrown at women's emotional problems.
- Poverty is one of the greatest impediments to health that minority women face. Poor women are much more susceptible to malnutrition, anemia, depression, and anxiety. Minority women who are poor have very limited access to the health system and are uninformed as to how the system operates. The medical profession should support programs to make health care services more accessible to poor minority women in both urban and rural settings.
- Language is the most tangible cultural difference and inhibits physician-patient communication which defers the attainment of health. Depression, anxiety, and other mental ailments may result. Every effort should be made by health professionals to communicate with minority women, particularly Hispanics, in language they easily understand. Health information, prescriptions, and other written communications should be prepared in language that is native to the patient.
- The medical profession should sponsor health education programs on nutrition, obesity, and diabetes for Native American populations.

Pauline Jackson, MD, Psychiatrist and Councilor, State Medical Society of Wisconsin, LaCrosse; *Tory Vollrath, MD,* Family Physician, Waukesha; *Beth Jones,* Conference Staff Coordinator and Community Health Coordinator, State Medical Society of Wisconsin; and *Anne Seiden, MD,* Chairperson and Psychiatrist, Department of Psychiatry, Cook County Hospital, Chicago, Illinois

"We want the issues to be raised so we can understand the problems and begin to correct them."—JULES LEVIN, MD

such as making inaccurate assumptions of neuroticism, hysteria or non-adaptiveness. The physician-patient interview and examination should be conducted with respect for the woman, sensitivity to her feelings, and recognition of the value of her time. The physician should be receptive to her requests for more information on diagnoses, treatment, and prescription drugs.

Attendance by 427 women signaled the success of the Conference and reflected the serious interest that Wisconsin women have in their health care. Media coverage was widespread and included radio, television, and the print media in every corner of the state.

The greatest complaint from conference participants was that more time was needed to formulate their recommendations for the State Medical Society. Virtually all of the participants who evaluated the conference requested a follow-up session on a specific women's health issue. The most prominent issue suggested for a future conference was women's mental health.

The Women's Health Issues Conference brought the women's movement and the consumer health movement together with health care professionals. It was a dynamic event, unique to Wisconsin and the country. The Wisconsin Women's Political Caucus passed a resolution at its recent state convention commending the State Medical Society for co-sponsoring the Conference. They applauded the sincere effort to bring women's concerns to the attention of the medical community.

WOMEN'S HEALTH ISSUES '79

CONFERENCE PLANNING COMMITTEE

GOVERNOR'S COMMISSION ON THE STATUS OF WOMEN
Kathryn F Clarenbach, PhD, Madison
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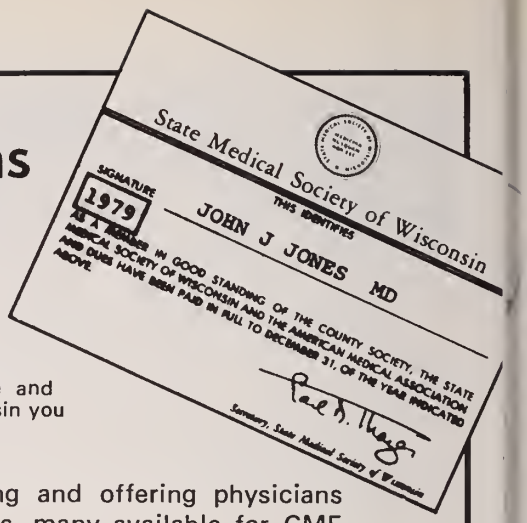
Discussion of women's health issues, though, did not end at the conclusion of the Conference. At the State Medical Society's Annual Meeting in May, the recommendations from the Conference were distributed to both the Council and the House of Delegates. The Council voted to establish an Ad Hoc Committee on Women's Health Issues to study the recommendations, put them in a form for distribution to appropriate State Medical Society committees, and, when appropriate, serve as an advocate for implementation of the recommendations. Committee members include:

Pauline Jackson, MD, LaCrosse
Kathy Bemmann, MD, Waukesha
Patricia Stuff, MD, Bonduel
Sandra Osborn, MD, Madison
Carl Eisenberg, MD, Milwaukee

The Women's Health Issues Conference and the subsequent creation of the Ad Hoc Committee of the Council on Women's Health Issues are assurances that women's voices will be heard by the medical profession and that Wisconsin physicians will do their part to make the health care system more responsive to their needs. ■

Why 4,788 physicians carry this card!.....



These are challenging times for any profession —times when you need the active, aggressive support of your national, state, and county medical societies to give you the professional edge you need to advance and grow. As a member of the State Medical Society of Wisconsin you receive many valuable benefits. Among them:

- **SMS Annual Meeting**—Sponsored each spring and offering physicians quality scientific and socio-economic programs, many available for CME credit.
- **Wisconsin Medical Journal and Medigram**—These publications bring you the latest in medical news affecting you and your patients.
- **Wisconsin Physicians Planning Network**—Is working to assure physician representation in the health planning process and new health services systems.
- **An Organized Lobbying Effort**—Working in Madison to ensure Wisconsin physicians have a voice in healthcare problems and issues presented to the Wisconsin Legislature.
- **Medical Assistance Agreement and Super-Rule**—The SMS Physicians Alliance is closely monitoring and negotiating the formulation of the Medical Assistance Provider Agreement and Super-Rule now mandated by state law.
- **Mediation and Peer Review**—Physicians, through a special commission, are "policing the profession" by mediating complaints of the public against physicians and where necessary imposing discipline.
- **Impaired Physician Program**—Was recently formed to help the impaired physician—the doctor suffering in some degree from alcoholism, other drug dependency, or mental illness.
- **Member Benefit Plans**—The Society offers comprehensive life, health, and liability insurance plans for physicians and their families at attractive group rates. In addition, physicians can receive practice management tips at seminars sponsored by the Society and take advantage of car rental and travel programs at special low, "member" rates.
- **Grassroots Political Action**—Developed through the SMS Physicians Alliance, local physicians meet with their legislative representatives on a regular basis to discuss issues of importance to medicine.
- **Community Health**—Society physicians are working with community organizations and individuals in providing consumer health education programs to promote a healthier Wisconsin citizenry.
- **CESF**—The Society's Charitable, Educational and Scientific Foundation, through its physician members, administers a student loan program to help students prepare for careers in healthcare; sponsors postgraduate teaching programs for physicians; and for the past two years, has participated in a Jail Health Care Accreditation Program of the American Medical Association.
- **Uniform Claim Form**—These forms, developed by the Society working with local insurance carriers, can be used by physicians in submitting claims to all private insurance companies in Wisconsin, Medicare, and Medicaid.

Scientific Medicine

The ubiquitous baron: A case of Munchausen syndrome in Wisconsin

REFER TO: Bingham WF: The ubiquitous baron: A case of Munchausen syndrome in Wisconsin. *Wisconsin Med J* 78:19-21 (July) 1979

KEY WORDS: Munchausen syndrome, factitious pain

William F Bingham, MD, La Crosse, Wisconsin

MUNCHAUSEN SYNDROME is one of many inappropriately coined eponymic entities that are firmly entrenched in the medical literature.[1] The term refers to patients with bizarre and complex medical histories who wander from hospital to hospital in search of treatment. Adroit and pathologic liars, they frequently fabricate symptoms and signs of serious disease; in fact, they will go to unbelievably painful and dangerous extremes to produce lesions to support their claims. They readily submit to surgical procedures, and regardless of the nature of the initial problem, Munchausen patients usually succeed in acquiring serious structural pathology after numerous well-meaning diagnostic and therapeutic efforts have been made on their behalf by unwary medical personnel.[2] In contrast to the patients who bear his name, Baron Munchausen was merely a droll raconteur whose whimsical tales were greatly exaggerated in print for profit by an impecunious acquaintance.[3] The Baron never showed any interest in medical problems, and he never underwent any surgical procedures. Other terms (hospital hoboes, hospital addiction, chronic factitious illness) have been suggested,[2] but Asher's original eponym[4] remains most popular.

Presented at the Sixth Annual Meeting of the Wisconsin Neurosurgical Society, La Crosse, Wisconsin, September 16, 1978. Doctor Bingham is a member of the Departments of Neurosurgery, Gundersen Clinic, Ltd, and La Crosse Lutheran Hospital. Reprint requests to William F Bingham, MD, Gundersen Clinic, Ltd, 1836 South Avenue, La Crosse, Wis 54601. Copyright 1979 by the State Medical Society of Wisconsin.

The purpose of this communication is to alert Wisconsin physicians—particularly orthopedic and neurologic surgeons—to the presence and *modus operandi* of a Munchausen patient within this state.

Case Report: A 56-year-old, white, male, Air Force veteran presented at the La Crosse Lutheran Hospital emergency ward with a chief complaint of sudden onset of severe low back and bilateral lower limb pain the previous day. He first developed low back pain in 1953 while serving in Korea. He was forced to bail out of his B-29 over enemy territory, and when his feet struck the ground, he developed intense low back pain. A helicopter rescued him behind enemy lines. Two days later an L5-S1 discectomy was performed in Seoul. He obtained complete symptomatic relief, but he was not returned to flying status.

In 1971 he developed recurrent low back pain, and an L4-5 discectomy and L4-S1 spinal fusion were performed at another military hospital. He was asymptomatic after several months. In 1973 he developed recurrent low back pain plus left lower limb weakness and fever. A myelogram performed at still another military hospital showed a "big abscess" which was "completely removed" surgically. He was hospitalized for only eleven days, and he did not require any outpatient antibiotics. After several months he felt "like a new man."

On December 1, 1977 he presented at the Hennepin County Medical Center (Minneapolis)

◄ *FIGURE 1—Anteroposterior tomogram of lumbosacral spine showing residual contrast material within the spinal canal and large right-sided L4-sacrum fusion mass. The L3-4 disc space is not depicted on this cut.*

FIGURE 2—Lateral tomogram of left side of lower lumbar spine showing extensive erosion of L3-4 disc space. ►

because of the abrupt onset of low back pain and left lower limb pain and weakness the previous day. He underwent an emergency myelogram which showed a complete block at L3-4. An emergency discectomy was performed, and "on the way out, they found a pus pocket." The organism cultured was *Staphylococcus aureus;* he was treated with clindamycin because of an alleged penicillin allergy. He was discharged January 7, 1978. He stated that he had been making an uneventful recovery at his home in western Wisconsin until March 25.

His appearance was "thin. . .appears chronically ill." Both lower limbs were diffusely wasted. He had good right lower limb strength, but there was moderate weakness of the left lower limb muscles. The left ankle jerk was absent; all other reflexes were brisk. All sensory modalities were decreased in the left lower limb. He had fair resting anal sphincter tone and voluntary contraction. He said that he had not voided for several hours; but when his bladder was catheterized, it was empty.

Abnormal laboratory findings on admission included a mild anemia with normal indices, low serum albumin, reversed albumin/globulin ratio and an erythrocyte sedimentation rate of 89 mm/hr. X-ray films of the lumbosacral spine showed a florid left-sided disc space infection at L3-4. He was afebrile. Multiple blood cultures were taken, but only a contaminant was recovered. Additional laboratory studies included tomograms (Figs 1 and 2) and CT scans (Fig 3) of the lumbar spine. During the latter procedure on March 31 his bladder was found to be grossly distended. He stated that he had had difficulty voiding earlier that day. When he returned to his room, he could void only by Crede. There were no objective changes on neurologic examination.

An emergency lumbar laminectomy was performed. No epidural abscess was encountered, only "soupy" granulomatous material within the L3-4 disc space from which *S. aureus* was cultured. He was started on intravenous clindamycin. Postoperatively the patient complained of considerable pain requiring frequent pentazocine injections. His neurologic examination was unchanged; however, it was now impossible to remove his Foley catheter.

Prior to surgery the patient had praised the medical and nursing staffs excessively. He sent the nurses flowers and candy on a daily basis. He telephoned the hospital chief administrator to tell him "this is the best hospital I have ever been in." He wanted to give the hospital $2500. A check through the Wisconsin Hospital Association quickly showed that this patient had been admitted to eight other institutions (Luther and Sacred Heart hospitals, Eau Claire; St. Joseph's Hospital, Chippewa Falls; VA, University and St. Mary's hospitals, Madison; Beloit Memorial Hospital; Memorial Hospital, Menomonie) within the previous two months. It also was learned that he was wanted by the Eau Claire police for passing bad checks.

The patient remained at La Crosse Lutheran Hospital until April 24. During that period he received continuous intravenous clindamycin. He precipitated numerous crises on the ward because of his failure to follow hospital regulations, *e.g.*, smoking in bed. When his cigarettes were taken, he managed to find them elsewhere. He burned holes in several sheets and triggered at least one fire alarm. His manner with physicians was obsequious, but he was abusive, hostile, demanding and sarcastic with nursing personnel. Confronta-

FIGURE 3—Computerized tomographic scan of L3 vertebra showing massive destruction of vertebral body, particularly on the left side.

tions about his bizarre attitudes and behavior only provided him the opportunity to flaunt his extraordinary pathologic lying. He threatened to sign out against medical advice several times. Because of a difference of opinion with his physician, he arranged on April 24 for his own transfer to St Francis Hospital in LaCrosse where intravenous clindamycin was continued for the next several weeks. During that hospitalization, it was learned that he had at least two aliases. He was discharged on May 24, but he failed to keep any of his follow-up visits.

Comment. This patient displays most, if not all, of the cardinal features of Munchausen syndrome. In all likelihood, many of his prior medical problems were due to structural pathology, and it is a moot point exactly how much he has contributed himself. The disc space infection introduces an iatrogenic element which is not surprising in view of the multiple diagnostic and therapeutic procedures he has undergone. In retrospect, the author feels that his episode of acute urinary retention on March 31 was factitious. He probably catheterized himself just before hobbling into the emergency ward, and his acute problem one week later represented a preexisting neurogenic bladder with overflow incontinence. During this hospitalization, he also had unusual dermatologic lesions which were later felt to be factitious.

ACKNOWLEDGMENT: The author is indebted to Doctor Joshua Goldbloom for his many helpful comments.

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Abstracts

Periorbital ultrasound findings

JONATHAN B TOWNE, MD; SERGIO SALLES-CUNHA, MSc; VICTOR M BERNHARD, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 114:158-160, 1979.

The direction of supraorbital and frontal artery flow and its response to compression of the superficial temporal, facial, and angular arteries were measured in 250 carotid arteries in 114 patients. All patients had arch and/or selective carotid arteriography. The carotid arteries were placed into the following three groups: hemodynamically normal, greater than 60% occlusion of the internal carotid artery, and total occlusion of the internal carotid artery. The test's accuracy was 94.5% in the hemodynamically normal group, 68.8% in the totally occluded group, and only 51.4% in the group with hemodynamically significant stenosis.

Although the carotid Doppler examination is not reliable in detecting hemodynamically significant lesions of the internal carotid artery, it is valuable in assessing the adequacy of collateral cerebral circulation. ■

Abstracts

Presented at the Fall Meeting of the WISCONSIN NEUROSURGICAL SOCIETY September 15-16, 1978, LaCrosse, Wisconsin

William F Bingham, MD, Vice-president and Program Chairman, LaCrosse, Wisconsin

Giant cell granuloma of the pituitary gland

Thomas A Duff, MD, Madison, Wisconsin
Charles Taylon, MD, Madison, Wisconsin

The authors presented a case study of a 50-year-old white male with a 24-hour onset of painless ophthalmoplegia. The subsequent workup was consistent with an intrasellar and cavernous sinus mass lesion. The patient underwent transsphenoidal hypophysectomy and the final pathology report revealed giant cell granuloma. Extensive workup for systemic granulomatous disease was negative. This is the first documented antemortem case of giant cell granuloma of the pituitary gland, as well as of painless ophthalmoplegia resulting from such a lesion. ■

Management of invasive tumors of the anterior base of the skull

Marc A Letellier, MD, Neenah, Wisconsin

Invasive tumors of the base of the skull have been classically approached by two methods: subtotal removal, or none at all. In 1969, Professor Derome of France advocated total resection of spheno-ethmoidal tumors through a subfrontal approach. We have applied and somewhat modified the techniques described by him in his comprehensive monograph of 1972. The following techniques were used in three of our cases.

(1) The first step is to proceed to a trans-nasal submucosal dissection to protect the mucosa from injury during the following intracranial procedure. This is necessary only if the midline base of the skull is to be reconstructed.

(2) A bifrontal craniotomy with excision of intradural tumor extension, if it exists, is performed. Then an epidural dissection with grafting of the midline and therefore isolation of the intradural contents is accomplished.

(3) We then remove the tumor from the base of the skull and reconstruct the base from autogenous iliac bone graft using both cortical and spongious bone once the defect has been evaluated after tumor removal.

The advantages of the techniques described are: (a) a clear view of the anatomy and pathology at hand without risk of injury to the intracranial contents, (b) the possibility of total removal with good reconstruction of the base of the skull free of cerebrospinal fluid leakage. Disadvantages are difficulty in length of the procedure and complete anosmia in all cases.

Case 1 was a 52-year-old white female with a status post-craniotomy for removal of an olfactory groove meningioma. Recurrence caused decrease in the visual acuity and invasion of the anterior bony fossa with extension into the ethmoid cells and sphenoid sinus. With the techniques described above we were able to remove totally the remaining tumor and improve markedly the visual acuity.

Case 2 was a 51-year-old female with status post-craniotomy for removal of a large right lateral sphenoid wing meningioma. Patient presented with continued progression of right exophthalmos and recent decrease in right visual acuity. The surgery provided complete relief of exophthalmos and some improvement of her vision.

Case 3 was a 20-year-old female with status post three craniotomy for partial removal of fibrous dysplasia and recurrence of bone cyst in the frontal bone causing marked pain, discomfort, and progressive right upper facial deformity. Complete and extensive removal of diseased bone prevented imminent compression of optic nerves bilaterally and provided complete relief of symptoms and good cosmetic correction of facial deformity.

Therefore, we advocate a more progressive approach to the problem of invasive tumor of the anterior base of the skull. ■

Treatment of metastatic spinal lesions

Michael J Ebersold, MD, Eau Claire, Wisconsin

Recently the treatment of metastatic spinal lesions has become somewhat controversial. The general incidence of metastatic spinal lesions is about one to two patients per 100,000 patients per year.

Although there are no controlled studies comparing surgical versus radiation therapy in very similar groups of patients, there are several points which almost all authorities seem to agree upon. Early diagnosis and histology of the tumor are probably the most important factors in the long-term prognosis of individuals with metastatic spinal lesions.

Although history and clinical examination are extremely important, myelographic confirmation of the lesion is necessary. Most authorities agree if the metastatic spinal lesion is radio-sensitive, if the neurologic loss is minimal and/or slowly progressive, and if other causes for the myelopathy and the myelographic block are ruled out, it is reasonable to proceed with radiation therapy to the spinal level after the patient has been placed on high-dose steroids.

If we are dealing with a radio-resistant tumor, if the neurologic loss is progressive in spite of radiation therapy, if neurologic deterioration is extremely rapid, or if there is any question about the nature of the myelographic block, then decompressive laminectomy with removal of as much tumor as surgically feasible is indicated.

Regardless of which form of therapy is selected, great care should be exercised in preventing some catastrophic neurologic loss which might develop due to instability of the spine. ■

Hydrocephalus secondary to aqueductal stenosis presenting at late adolescence and adult life

Byron L Annis, MD, LaCrosse, Wisconsin

The case histories of patients presenting during the second and third decades of life with hydrocephalus secondary to aqueductal stenosis were presented. In two patients it seemed obvious that hydrocephalus had been present from at least childhood. The symptoms that brought the patients to neurosurgical attention were slowly progressive and included headache, urinary incontinence, and gait disturbance. In both patients there was mild impairment of intellectual function. Another patient presented with signs and symptoms of rapidly increasing intracranial pressure. The final patient discussed was essentially asymptomatic but was discovered to have papilledema during a physical examination for high school athletics. All patients improved following ventricular shunting.

An extensive neurodiagnostic workup in order to exclude an occult, but potentially treatable, peri-aqueductal neoplasm was recommended.

The results of neurosurgical therapy in adolescents and adults with aqueductal stenosis have been rather disappointing because of high morbidity and mortality. Most articles available were written prior to the development of ventriculo-vascular and ventriculo-peritoneal shunt diversion procedures. It is anticipated that modern diagnostic and therapeutic modalities that are generally available may significantly improve the results of therapy. Our experience indicates, however, that these patients were exquisitely shunt-dependent and in this discussion, questions were raised about the possibility of employing additional modes of therapy. ■

Cadaver renal transplantation: the role of the neurosurgeon

Douglas T Miller, Madison, Wisconsin
Renal Transplant Coordinator

There are currently about 160 Wisconsin men, women, and children who are candidates for kidney transplantation waiting for a cadaver kidney to give them a new chance at a normal life. Few realize that their chances depend as much on the neurosurgeon and the neurologist as on the transplant surgeon.

The number of cadaver kidneys referred for transplantation depends mainly on the understanding and cooperation of the neurosurgeon, the physician often in attendance of a fatally brain-injured, potential donor. It is the neurosurgeon who determines when brain death has occurred, who has the earliest opportunity to approach the next of kin or the transplant team about organ donation, and who can recommend maintenance of the brain-dead patient until the kidney can be recovered.

It is the neurosurgeon who is often in the best position to explain to the bereaved family that transplantation of a cadaver kidney is a dire need, and a therapeutic reality offering significant physical, sociological, and psychological benefits to the patient with end-stage renal disease. The financial benefits to our healthcare system also are considerable. Chronic, in-center dialysis costs $25,000 per patient per year. The cost of a successful transplant is $12,000 to $20,000 per patient and then roughly $500 to $1,000 per year thereafter for follow-up and immunosuppressive drug therapy.

At the University of Wisconsin Hospitals in Madison, every attempt is made to send the kidney patient home either with a functioning transplanted kidney or in good condition back on dialysis. Of the patients receiving cadaver kidneys at our institution between January 1975 and August 1978, 57% of the kidneys are functioning after 44 months post-transplantation and 90% of the patients are surviving during the same period. Transplant patients rejecting a graft but who are otherwise in good health may receive a second transplant. This is the preferred treatment rather than subjecting the patients to massive doses of immunosuppressive drugs.

When a neurosurgeon makes a cadaver donor referral, as soon as proper consent is obtained, the University of Wisconsin Hospital Kidney Preservation Team travels immediately to the referring hospital, recovers the kidneys, and pays all costs incurred.

Currently, over 110 ready recipients on dialysis are waiting for a compatible cadaver kidney at University Hospitals. The help of the neurosurgeon in acquiring such kidneys is invaluable. ■

Treatment of increased intracranial pressure in acute brain injury with thiopental

Allan B Levin, MD, Madison, Wisconsin
Lawrence J Frazin, MD, Milwaukee, Wisconsin

Control of increased intracranial pressure (ICP) in patients with acute brain injury has proved to be important in obtaining increased and improved quality of survival. The use of ICP monitoring and techniques of hyperventilation and intermittent doses of hyperosmotic agents resulted in control of ICP in approximately 66% of these patients with a good quality survival rate of approximately 52%. Patients who did not respond either required massive decompressive craniectomies with overall poor results or died.

In November 1976, we introduced the use of thiopental coma in the treatment of increased ICP unresponsive to other agents. With the use of thiopental we have been able to control intracranial pressure in approximateley 92% of our patients with good quality survival in 70%. This mode of therapy, however, requires a stringent protocol that includes criteria for patient placement on thiopental, extensive monitoring of the patient, dosage of thiopental to be given and the use of additional medication.

Criteria for the use of thiopental must include: (1) increased intracranial pressure uncontrolled by other means [hyperosmotic agents, hyperventilation, etc], (2) patient must be intubated and on ventilatory assistance, (3) evidence of brain activity prior to the use of thiopental and (4) absence of gross evidence of irreversible brain stem damage. Prior to the initiation of thiopental, the patient should have a CT scan and/or angiogram to rule out a remedial surgical lesion. Monitoring during the use of thiopental must include: (1) intracranial pressure monitoring, (2) ECG, (3) arterial line, (4) CVP or pulmonary artery catheter, (5) nasogastric tube, (6) Foley catheter and (7) toe temperature recording. A loading dose of thiopental is given plus a continuous drip to maintain acceptable intracranial pressure levels and maintain a perfusion pressure >40 torr. A lower perfusion pressure may require either the use of a Dopamine drip or if this is ineffective then the dosage of thiopental must be decreased. ■

Third ventricular tumors

Glenn A Meyer, MD, Milwaukee, Wisconsin

The table summarizes the author's treatment of ten intracranial tumors arising within or encroaching upon the third ventricle during the years 1971 through 1977. Seven were operated by an interhemispheric transcallosal approach and one by a transfrontal cortical incision. Two (cases 4 and 7) were in extremis preoperatively due to brain stem decompensation. The operative mortality was zero and all seven survivors are now improved from their preoperative neurological status. Five of the seven surviving patients have returned to full activity and three have likely been cured of their lesions. The operative morbidity consisted of two patients who had a mild hemiparesis persisting for a few days following retraction of one cerebral hemisphere for an interhemispheric approach. Three patients had a longer lasting but temporary hemisensory and/or visual field defect. Two surviving cases have a mild disconnection syndrome from section of the posterior corpus callosum. This is demonstrable by neuropsychological testing, and although presumably permanent, is a handicap in only one patient (case 4) who is attempting to relearn writing skills with the left (nondominant) hand. There was one late complication of a skull osteomyelitis requiring delayed cranioplasty. Three deaths resulted from recurrent tumor 9 to 17 months postoperatively.

	Sex	Age	Tumor	Operated	Shunted	Alive	Well
POSTERIOR LESIONS							
1	F	10	Pinealoma	+	+	−	−
2	M	18	Malignant glioma	+	+	−	−
3	F	59	Meningioma	+	−	+	+
4	F	18	Hematoma (? abscess)	+	+	+	−
ANTERIOR LESIONS							
5	M	12	Craniopharyioma	+	+	−	−
6	F	46	Colloid cyst	+	−	+	+
7	F	19	Glioma	+	+	+	+
8	F	19	Glioma (tuberous sclerosis)	+	+	+	−
9	F	38	Unknown	−	+	+	+
10	M	45	Unknown	−	+	+	+

The presenting signs and symptoms were widely variable but included two patients diagnosed as having multiple sclerosis and one diagnosed as psychiatrically ill. The CT scan was by far the most efficient diagnostic test.

Conclusions:

(1) Tumors of the pineal gland, posterior superior aspect of the thalamus, and areas surrounding the foramen of Monro are surgically accessible with acceptable morbidity. The operating microscope is essential for successful intraventricular dissection of these lesions.

(2) When operating on obstructing tumors in the area of the foramen of Monro (cases 7 and 8), it is advisable to fenestrate the septum pellucidum to eliminate the need for bilateral shunts.

(3) There is a significant chance of nonmalignancy (30-50%): perhaps greater with anterior than with posterior third ventricular masses.

(4) Most lesions incompletely removed should be given radiation therapy; very few should be irradiated without a tissue diagnosis.

(5) With small obstructing lesions (cases 9 and 10) in the region of the foramen of Monro the best course of action may be a cerebrospinal fluid shunt followed by observation of the lesions with serial CT scans. ■

Obstructive jaundice and perinephric abscess

VICTOR S FALK, MD, Edgerton, Wis: *Arch Surg* 113:778 (June) 1978

Only four cases of obstructive jaundice secondary to varying renal problems have been recorded.[1] A fifth case, due to perinephric and periureteral abscess, is reported here.

Report of a Case.—A 79-year-old woman had been admitted eight months previously with contusion of the abdominal wall. Roentgenographic studies fortuitously included an intravenous pyelogram interpreted normal. Readmission in July 1973 was for right upper quadrant and shoulder pain of several weeks' duration. Her urine had been dark and the stools light. There was no prior history of icterus despite food intolerances. Temperature was 38.9 C; heart rate, 120 beats per minute. The patient was grossly icteric, and the total bilirubin level was 10.1 mg/dl. The SGOT, SGPT, alkaline phosphatase, and WBC values were elevated. There was tenderness in the right upper quadrant. Upper gastrointestinal series showed "air-bubblelike densities" in the right upper quadrant, interpreted as probable subdiaphragmatic and hepatic abscess.

The patient's condition improved with intravenous fluids and antibiotics. On the fourth day, the abdomen was explored through a right upper quadrant incision. The liver and gallbladder were unremarkable, but there was a large retroperitoneal mass surrounded by friable necrotic tissue and adherent bowel. This was the right kidney, and it was shelled out from its necrotic capsule. Nephrectomy and convalescence were uneventful. *Clostridium perfringens* and *Bacteroides fragilis* were cultured. The pathological diagnosis was periureteral and perinephric abscess. The patient is currently well.

Comment.—Obstructive jaundice due to renal pathology is rare.

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Perinatology

Editor: LUIS B CURET, MD
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Intrauterine growth retardation

Luis B Curet, MD, Madison, Wisconsin

EDITORIAL NOTE: A recent review of the literature revealed that in spite of a significant perinatal morbidity and mortality associated with fetal intrauterine growth retardation, the diagnosis is entertained rather infrequently. The accompanying article outlines an approach which should improve detection and outcome of the condition.

THE DEVASTATING EFFECTS of fetal intrauterine growth retardation have been amply documented.[1,2,3] Perhaps because the condition is seen in only 1-4% of pregnancies, physicians do not entertain the diagnosis often enough to proceed to either rule it in or out.

Tejani *et al*[3] made the diagnosis of IUGR prenatally in only 34% of their cases while Perry *et al*[4] diagnosed it in only 22% of their cases. In view of the high incidence of placental dysfunction and perinatal mortality, it is extremely important that a high index of suspicion for IUGR be maintained. At the University of Wisconsin Maternal Intensive Care Unit at Madison General Hospital, we have followed the following protocol:

1. Patients have uterine fundal height measurements with a tape at every visit. There is a roughly 1:1 ratio between weeks gestation and centimeters of fundal height between 22 and 36 weeks. If the fundal height measurement lags by more than 3 cm for a particular week gestation, the patient is suspected of having IUGR.
2. Such patients have weekly oxytocin challenge tests (OCT), and in addition, 24-hour urinary estriol collections three times per week.
3. A definite diagnosis of IUGR is made if there is fundal lag of more than 3 cm, urinary estriols are low and fixed, and the OCT is positive. These patients are delivered immediately if the fetus has pulmonary maturity. Otherwise, expectant treatment in the hospital is undertaken.
4. A probable diagnosis of IUGR is made if fundal height lags, estriols are low and fixed, but the OCT is negative. These patients are kept on the placental evaluation protocol until 38 weeks gestation when they are induced if fetal maturity has been established.
5. If the fundal height lags but the estriols are normal, the OCT is negative, and the fundal height grows appropriately over a 4-week period of observation, the diagnosis of IUGR is discarded.
6. Patients suspected of IUGR undergo ultrasonic measurement of the fetal biparietal diameter (BPD) every two to three weeks. However, we have not found these serial determinations of fetal BPD to be useful as in the great majority of cases of IUGR the fetal brain is spared.

Over the past year we have followed 26 pregnant patients suspected of having IUGR. Of those, only 10 (38%) had the diagnosis confirmed after birth. However, when the diagnosis was suspected after 34 weeks gestation, the accuracy increased to 60%.

Of more practical importance, however, was the fact that during the period of the study, there was no IUGR baby born on whom the diagnosis was not suspected prenatally. In other words, some patients with normal babies were entered into the placental evaluation program, but not a single IUGR baby was missed. There were no perinatal deaths during the study period.

Based on our observations and those of other investigators, we would strongly recommend that any pregnant patient with a uterine fundal height lagging by more than 3 cm from the expected height should be suspected of having an IUGR fetus and should be entered into a well-defined medical management plan which includes placental evaluation. Because of the complexity of the problem, we believe that these patients should be managed at a perinatal center.

From the Department of Gynecology-Obstetrics, University of Wisconsin and the Perinatal Center, Madison General Hospital. Publication support provided by the Wisconsin Perinatal Center, Southcentral Region, Madison. Reprint requests to: Wisconsin Perinatal Center, Southcentral Region, 202 South Park St, Madison, Wis 53715. Copyright 1979 by the State Medical Society of Wisconsin.

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4. Perry CP, Harris RE, et al: *Obstet Gynec* 48:182, 1976. ■

This Wisconsin data—showing the effect of age upon inhospital surgical mortality for therapeutic procedures among the State's aging population—should help surgeons make more accurate assessments of operative risk in elderly citizens.

Aging and surgical risk in older citizens of Wisconsin

E D Sikes Jr, MA, MSIE and **Don E Detmer, MD,** Madison, Wisconsin

• Weighing the surgical risk is an important factor in considering any patient a candidate for an operative procedure. This paper reports recent Wisconsin data showing the effect of age upon inhospital surgical mortality for therapeutic procedures among the State's aging population. The data show that over age 75 the procedure-adjusted mortality rate begins to climb. Risks at 90-94 years of age are nearly twice those at 75-84. Risks at 80-84 years are nearly twice those of 0-69 years. These trends hold true for both elective and urgent/emergent procedures. These data should help surgeons make more accurate assessments of operative risk in elderly citizens. From the perspective of increasing surgical risk, old age appears to begin around 75-79 years of age.

SURGEONS TYPICALLY generate a likely risk of operative mortality in considering whether to recommend a surgical procedure. A substantial amount of surgery is performed on elder citizens, and this is likely to increase as we become more of a geriatric culture. Other investigators have reported upon the effect of age, primary surgical disease, and coexisting diseases on surgical mortality and longterm prognosis.[1,2,3] However, none of these data are based upon Wisconsin experience. For this reason we have analyzed our state data, and this report shows the effect of age upon inhospital surgical mortality for therapeutic procedures among the state's aging population.

Doctor Detmer is a vascular surgeon and team physician at University of Wisconsin Hospitals and Director of the Administrative Medicine Program at the University of Wisconsin-Madison; he also is Quality Research Director for the Wisconsin Professional Review Organization. Mr Sikes is a Health Data Analyst at the Wisconsin Professional Review Organization. This research was done under Contract HSA 105-74-160 between the United States Department of Health, Education, and Welfare and the Wisconsin Professional Review Organization. Opinions expressed are those of the authors and not necessarily those of the Wisconsin Professional Review Organization. Reprint requests to: Don E Detmer, MD, Quality Research Director, Wisconsin Professional Review Organization, PO Box 1109, Madison, Wis 53701. Copyright 1979 by the State Medical Society of Wisconsin.

Materials & methods. The data used in this study were obtained from the Wisconsin Professional Review Organization (WisPRO). WisPRO is the federally mandated Professional Standards Review Organization for the 65 counties of Wisconsin excluding the seven-county Milwaukee area. Records for hospital discharges during 1977 were analyzed. These data refer to hospital stays during which therapeutic surgical procedures were performed. The procedures and the primary diagnoses which most frequently accompany a subset of these procedures are shown in Tables 1 and 2, respectively. Diagnostic procedures were not included in this assessment of risk. Of all patients who expired during their hospital stay during or after nondiagnostic operative procedures, the procedures on the list in Table 1 account for 58.1% of all deaths. The procedures account for 58.6% of such deaths in patients age 65 or over.

Comment deserves to be made about the percentage of all hospital care which the WisPRO data set encompasses. For patients 65 and over the WisPRO data set is essentially a complete record of all hospitalizations of the elderly in Wisconsin excepting the area around Milwaukee. Of all admissions reported to WisPRO, three-fourths are in the Medicare Part A entitlement which includes patients age 65 or over. The remaining one-fourth of WisPRO data comes from Medicaid or the Child and Maternal Health Care Program. For the under-65 population the data do not represent a complete record of hospitalizations although they include a fairly large sample of Wisconsin hospitalization experience.

For purposes of this study the patients were divided into seven age groupings: 0-64, 65-69, 70-74, 75-79, 80-84, 85-89, and 90-94. Too few patients were available for an analysis over age 94. For each of the age groups mentioned, an unadjusted mortality rate was calculated for the entire collection of procedures listed in Table 1.

Table 1—Procedures studied (listed by frequency) together with corresponding H-ICDA-2 and ICDA-8 codes*

PROCEDURE	CODES	CASES
1. Operations on cardiovascular system	H: 35.0-39.9, 93.3, 93.4 I: 24.0-30.9	3,306
2. Transurethral prostatectomy	H: 60.2 I: 58.2	2,540
3. Repair of inguinofemoral	H: 53.0-53.3 with diagnosis 550-551.1 I: 38.2-38.5 with diagnosis 550-551.0	1,943
4. Cholecystectomy *without* common bile duct procedure	H: 51.1 without 51.3-51.6, 51.8 I: 43.5 without 43.0-43.3	1,739
5. Open reduction-internal fixation	H: 79.3 I: 82.5, 82.9, 83.2, 83.5, 84.3, 84.7	1,437
6. Arthroplasty of hip	H: 81.5, 81.6 I: 87.1	1,358
7. Subtotal resection of large bowel	H: 45.5 I: 47.5	830
8. Excision of skin lesion	H: 88.5 I: 92.1	755
9. Cholecystectomy *with* common bile duct procedure	H: 51.1 with 51.3-51.6, 51.8 I: 43.5 with 43.0-43.3	302
10. Below knee amputation	H: 84.7 I: 85.7	230
11. Above knee amputation	H: 84.8 I: 85.8	219
12. Repair of inguinofemoral hernia *with* obstruction	H: 53.0-53.3 with diagnosis 552-553.1 I: 39.2-38.5 with diagnosis 552-553.0	218
13. Bowel exteriorization, colostomy	H: 46.0, 46.1 I: 47.1, 47.8	201
14. Thoracotomy	H: 34.1 I: 32.0	196
15. Toe Amputation	H: 84.5 I: 85.5	189
16. Craniotomy	H: 01.1 I: 01.0	150
17. Resection of small bowel	H: 45.4 I: 47.4	138
18. Excision of liver lesion	H: 50.2 I: 42.1	113
19. Temporary tracheostomy	H: 31.1 I: 20.5	66

*ICDA-8: Eighth Revision, International Classification of Diseases, Adapted for Use in the United States

H-ICDA-2: Hospital Adaptation of ICDA, Second Edition

TABLE 1—Shows the 19 procedures studied, including their corresponding H-ICDA-2 and ICDA-8 codes.

Table 2—Primary discharge diagnoses most frequently associated with selected procedures from Table 1

1. Operations on cardiovascular system
   - Chronic ischemic heart disease
   - Malfunction of mechanical (cardiac) pacemaker
   - Occlusive disease of precerebral arteries (without paralysis)
   - Abdominal aortic aneurysm
7. Subtotal resection of large bowel
   - Malignant neoplasm of sigmoid colon
   - Malignant neoplasm of cecum
   - Diverticulitis of colon
   - Malignant neoplasm of large intestine, part unspecified
8. Excision of skin lesion
   - Lipoma of skin and subcutaneous tissue
   - Malignant neoplasm of skin—other and unspecified parts of face
   - Sebaceous cyst
13. Bowel exteriorization, colostomy
   - Malignant neoplasm of sigmoid colon
   - Diverticulitis of colon
   - Malignant neoplasm of rectum
14. Thoracotomy
   - Malignant neoplasm of bronchus and lung
   - Spontaneous pneumothorax
16. Craniotomy
   - Subarachnoid, subdural, and extradural hemorrhage following injury—without mention of open intracranial wound
   - Benign neoplasm of cerebral meninges
17. Resection of small bowel
   - Intestinal or peritoneal adhesions with obstruction
   - Embolism and thrombosis of mesenteric artery
18. Excision of liver lesion
   - Secondary malignant neoplasm of liver
   - Laennec's cirrhosis
19. Temporary tracheostomy
   - Chronic obstructive lung disease
   - Respiratory failure

TABLE 2—Gives an indication of the pathology underlying nine of the procedures studied.

TABLE 3—The increase in mortality rate as a function of age for the procedures studied is shown.

Table 3—Mean mortality rate for procedures studied

AGE GROUP	NUMBER OF ADMISSIONS	UNADJUSTED MORTALITY RATE (%)	PROCEDURE-ADJUSTED MORTALITY RATE (%)
0-64	2,673	2.7	2.6
65-69	3,764	3.6	3.3
70-74	3,396	3.5	3.5
75-79	2,541	4.4	4.5
80-84	1,956	6.2	6.0
85-89	1,157	7.2	7.8
90-94	443	10.8	10.3

Next, a "procedure-adjusted" mortality rate was calculated for each age group to adjust for the fact that some age groups have a higher relative frequency of certain procedures and might thus be assigned an unfairly biased mortality rate. In calculating the procedure-adjusted mortality rate for a given age group, the group's mortality rate for each of the 19 procedures was weighted by that procedure's relative frequency among patients aged 65-94.

Results. The procedure-adjusted and unadjusted mortality rates are shown in Table 3. Examination of the procedure-adjusted mortality rate shows a steady increase in mortality rates with increasing age. This trend is statistically significant across the seven age groups ($p<.001$ using a chi-square test). When the procedure-adjusted rates for the age groups were compared in pairs, only two of the six pairs of consecutive age groups were significantly different ($p<.05$ for the third and fourth groups and also for the fourth and fifth groups). Indeed, the procedure-adjusted rates for ages 65-69 and 70-74 are quite close. When pairs of age groups one step apart (*eg,* ages 65-69 and 75-79) were compared, all five possible pairs were significantly different ($p<.05$ for the first two pairs, $p<.002$ for the last three pairs) by chi-square. The increasing risk of age in the procedure-adjusted mortality rate is shown graphically in Figure 1. Risks at 90-94 years of age are nearly twice those at ages 75-84. Further, risks at 80-84 are nearly twice those of all ages up to 69. From the perspective of increasing surgical risk, old age currently appears to begin in Wisconsin around 75-79 years of age.

Table 4—Mortality rates and frequency for each of the procedures studied (WisPRO data for discharges during 1977)

	AGE 25-74 YEARS		AGE 75-94 YEARS	
	NUMBER OF CASES	MORTALITY RATE (%)	NUMBER OF CASES	MORTALITY RATE (%)
Repair of inguinofemoral hernia without obstruction	1,181	0.2	518	0.6
Transurethral prostatectomy	1,367	0.3	1,284	1.9
Cholecystectomy without bile duct procedure	1,184	0.9	438	4.8
Arthroplasty of hip	704	1.6	735	4.6
Excision of skin lesion	418	1.7	271	1.1
Open reduction-internal fixation	517	1.7	952	7.1
Cholecystectomy with bile duct procedure	167	2.4	129	7.0
Repair of inguinofemoral hernia with obstruction	96	3.1	111	7.2
Toe amputation	119	3.4	76	6.6
Subtotal resection of large bowel	496	3.8	368	7.9
Operations on cardiovascular system	2,352	6.4	959	11.4
Excision of liver lesion	88	8.0	28	10.7
Below knee amputation	117	8.5	121	9.1
Above knee amputation	84	13.1	148	16.2
Craniotomy	106	14.2	33	21.2
Bowel exteriorization, colostomy	110	14.5	106	17.9
Resection of small bowel	80	15.0	62	16.1
Thoracotomy	140	15.0	51	9.8
Temporary tracheostomy	48	27.1	18	55.6

TABLE 4—Lists the procedures studied in order by increasing mortality rate (for ages 25-74). Also illustrates how the rate differs between age groups 25-74 and 75-94.

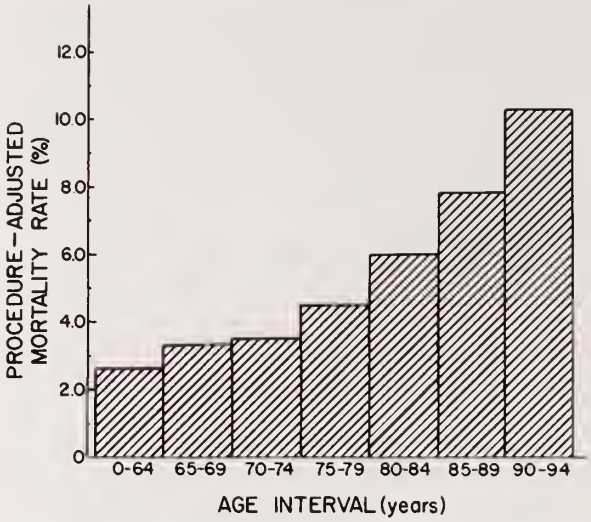

FIGURE 1—Shows graphically the increase in procedure-adjusted mortality rate with age. Note the disproportionate rise in risk which occurs as age increases.

The crude mortality rate for each of the 19 procedures in the study is shown in Table 4. Mortality rates for the 19 procedures cover a broad range in terms of risk of death. (The high mortality rate for temporary tracheostomy is to be expected since this procedure tends to be a final emergency procedure used in near-terminal cases.) A further analysis of procedure-adjusted mortality risks shows that risks as a factor of age increase for the elective procedures as much as for the more urgent/emergent problems; *eg,* inguinal hernia without obstruction versus bowel exteriorization.

These data should help physicians caring for elderly citizens make more accurate assessments of operative risk in the elderly. Obviously a number of these operative procedures are not elective in nature. However, a good number of them are. We believe that this epidemiologic data of surgical risk will help clinicians make better *a priori* assessments of surgical risk, especially in those patients being considered for elective surgery.

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Abstracts

Terbutaline's effects on the allergy skin test

Stephen A Imbeau, MD: Richard Harruff, MD: Marsha Hirscher: Charles E Reed, MD; University of Wisconsin Center for Health Sciences, Madison, Wis: *J Allergy Clin Immunol* 62:193-196 (Oct) 1978

Beta adrenergic agents are known to inhibit mediator release from skin and lung mast cells in vitro, and isoproterenol and epinephrine are known to impair the immediate allergic skin test reaction. We undertook to investigate the effects of aqueous and oral terbutaline, a beta adrenergic agent, on the allergy skin test. Ten ragweed-sensitive subjects were tested intradermally with ragweed extract mixed with either placebo or aqueous terbutaline in a double-blind fashion with several different concentrations of terbutaline on both arms. The immediate reaction was measured after 15 minutes and the late reaction site was biopsied after six hours. No significant difference could be found regardless of the terbutaline concentration.

End point skin test titration studies with ragweed antigen performed 90 minutes after either placebo (oral) or 5 mg of oral terbutaline also revealed no significant effect of the active drug on the immediate skin test reaction size. Terbutaline mixed with ragweed antigen does not affect the immediate or late allergic skin reactions; furthermore, 5 mg of oral terbutaline does not inhibit the immediate allergy skin test. ■

Serum lithium levels and long-term diuretic use

James W Jefferson, MD and Ned H Kalin, MD, University of Wisconsin Clinical Sciences Center, Madison, Wis: *JAMA* 241:1134-1136 (Mar 16) 1979

In normal volunteers whose conditions were stabilized with lithium carbonate, there were no significant changes in serum lithium levels during a two-week period while they received 40 mg/day of furosemide. During another two-week period, a 50 mg/day dosage of hydrochlorothiazide did cause a significant rise in serum lithium levels. These observations suggest that a substantial amount of lithium may be reabsorbed in the loop of Henle and that the combined use of lithium and a loop diuretic may not require modification of the lithium dosage. ■

Abstracts

Chronic pancreatitis: a cause of biliary stricture

William J Schulte, MD; Anthony J Laporta, MD; Robert E Condon, MD; George F Unger, MD; Joseph E Geenen, MD, Surgical Services, Wood Veterans Administration Center, Wood, Wis: *Surgery* 82:303-309 (Sept) 1977

In 13 patients who had had a distal common duct stricture associated with chronic relapsing pancreatitis, all, when first seen, had an elevated alkaline phosphatase level; eight also had an elevated serum bilirubin level. Five patients with jaundice had a febrile course; a preoperative diagnosis of acute cholangitis was made in four of these. Eight of the 13 patients have had a choledochoduodenostomy for relief of biliary obstruction; seven are living and well; one died of continued alcoholism and pancreatitis. One patient had a loop cholecystojejunostomy; decompression was inadequate and death due to septicemia secondary to ascending cholangitis ensued. Four patients have not yet had surgery. Two are symptomatic, but elective operation was refused. Two were lost to follow-up. Investigation of the biliary tract is recommended in patients known to have chronic relapsing pancreatitis who also have persisting abdominal symptoms and an elevated alkaline phosphatase. ■

Comparison of caval filters in the management of venous thromboembolism

Max Wingerd, MD; Victor M Bernhard, MD; Frank Maddison, MD; and Jonathan B Towne, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 113:1264-1271, 1978

Over a seven-year period, 38 Mobin-Uddin MU and 33 Kim-Ray Greenfield KG vena cava filters were inserted in 71 patients with no substantial complications or deaths directly related to the surgical procedure. Thirteen of the 16 early deaths were due to progression of associated diseases. The remaining three deaths were caused by pulmonary emboli and occurred in each instance after insertion of a MU filter. None of the 14 late deaths were related to the caval filter or sequellae of venous thrombosis. Inferior vena cava patency was objectively assessed in 36 patients by cavagram (22) or autopsy (14). Caval patency of 95% (18 of 19) in those with KG filters was significantly greater than the 47% patency (eight of 17) seen with MU devices ($P<.01$). Gray scale ultrasound, when successful in visualizing the vena cava, was found to be a reliable indicator of patency. Venous stasis phenomena were noted in 50% of those with a patent cava and in 70% of those with an occlusion. Thus, it is not surprising that edema was found in only 38% of the patients as compared with 75% of the patients with the MU filter.

Both of these devices are safe to insert. However, on the basis of superior patency rate, lower incidence of stasis phenomena, and the absence of recurrent pulmonary emboli in our series, we prefer insertion of a KG filter when caval interruption is required. ■

Primary tumors of the external and middle ear

Richard M Hansen, MD and Joseph A Libnoch, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Intern Med* 138:1137-1138 (July) 1978

A 78-year-old man with untreated chronic lymphocytic leukemia (CLL) was revaccinated for smallpox. A severe local reaction and generalized rash followed that responded to treatment with vaccinia immune human globulin. After recovery, the leukocyte count fell to normal and all evidence of CLL disappeared. He remains in complete remission three years after smallpox vaccination. ■

Toxicity of penicillamine

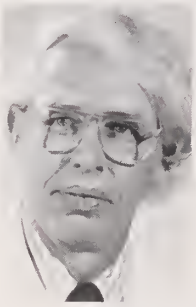
Paul B Halverson, MD; Franklin Kozin, MD; Gerson C Bernhard; and Allan L Goldman, MD, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 240:1870-1871, 1978

A retrospective study of penicillamine toxicity in 156 patients, under treatment for rheumatoid arthritis, yielded a high incidence of toxic reaction (62%), necessitating discontinuation of the drug therapy in 36% of the patients. Of the total group, proteinuria occurred in 14%, hematologic toxic reaction in 11%, mucocutaneous toxic reaction in 28%, and gastrointestinal intolerance in 12%. ■

A tribute to Doctor Caldwell

THE STAFF OF THE Wisconsin Clinical Cancer Center and the Departments of Human Oncology and Radiology of the Clinical Science Center of the University of Wisconsin Medical School in Madison, Wisconsin, were shocked by the recent death of Dr William L Caldwell, Director of the Division of Radiation Oncology, and Professor of Human Oncology and Radiology.

Doctor Caldwell had been vacationing with his wife and his wife's cousin at a remote resort about 60 miles north of Fort Francis, Ontario. Both he and the cousin were found dead Monday, May 21. According to the coroner, the cause of death was due to carbon monoxide poisoning, probably due to a faulty propane stove or refrigerator. Mrs Caldwell is recovering.



Doctor Caldwell was born November 12, 1929, in Honolulu, Hawaii. He received his MD degree from Stanford University in 1955. While a radiology resident at Stanford University Hospitals from 1956-1959, Doctor Caldwell had papers published in the *Stanford Medical Bulletin* on the demonstration of fracture dislocations and spinal problems. He was certified by the American Board of Radiology in Radiology and Nuclear Medicine in 1960.

Adding to his range of experiences was the period from 1959-1963 when he was chief of the Radiology Service at Rodriguez US Army Hospital in San Juan, Puerto Rico, and did research at the Puerto Rico Nuclear Center. While in Puerto Rico, he studied x-rays of the small bowel in people with tropical sprue. Also he did some basic research on the increased resistance of rats to *Schistosoma masoni* after exposure to larvae which had been treated with gamma radiation. He also began his life-long interest in the side-effects of radiation with special concern regarding the problem of radiation nephritis.

His research studies took him to the Royal Marsden Hospital in Sutton, Surrey, England and the Institute of Cancer Research in London, where he developed an interest in the relationship between time and dose of irradiation with x-rays or fast neutrons to survival and the development of side-effects. He then spent a few years at Vanderbilt University Hospital in Nashville, Tennessee where he rose from an associate professor to professor of radiology. There he studied ways to treat bladder and testicular cancers.

Wisconsin was honored when Doctor Caldwell came to the University of Wisconsin Hospitals in Madison in 1971 as the director of the Radiation Oncology Division. Shortly thereafter this division combined with the Division of Clinical Oncology to become the Wisconsin Clinical Cancer Center in 1973, and he became an associate director. He established the School of Radiation Therapy Technology which has graduated 40 students since its foundation in 1972. He also assumed the directorship of the Radiation Oncology Resident training program.

Doctor Caldwell was an early promoter of plans for fast neutron and negative pion radiotherapy facilities at various centers. Always looking to the future, he was interested in integrating the various cancer treatment modalities and searched for ways to improve cancer treatment with less morbidity for the patients. Recently he had become involved in the possibilities of treating cancer with hyperthermia.

Doctor Caldwell was associated with a number of national and state radiology and oncology groups, and served on many national committees involved in education and therapeutic programs. He was the author of a textbook, *Cancer of the Urinary Bladder,* and wrote other medical texts as well as contributing 62 publications to scientific journals. He assisted in the preparation of a guide for planning radiotherapy facilities for the American College of Radiology in 1976. Since 1978 he had served as an associate editor of the *International Journal of Radiation Oncology, Biology, and Physics.*

A memorial service for Doctor Caldwell was held May 28. A memorial scholarship in Radiation Oncology has been established in his honor. Gifts for this can be sent to the Radiation Oncology Division of the Wisconsin Clinical Cancer Center.

Although no one can explain why such a tragedy as this should happen, it is hoped that the leadership and concern that Doctor Caldwell so well portrayed in his work will instill in each of us the desire to try to continue those endeavors he had begun, to exhibit those humane qualities he showed in his daily life, and to express the loving concern that he shared with those he touched in his far-reaching network of activities.—DOROTHY J BUCHANAN-DAVIDSON, PHD

Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Head and Neck Cancer Control Network completes five years in Wisconsin

In 1974 the National Cancer Institute designated Wisconsin as one of the first five Head and Neck Cancer Control Networks in the country, with Dr James Brandenburg of the University of Wisconsin Medical School as the Chief Investigator. The Wisconsin Network is unique because it serves the entire state rather than just the area surrounding a major hospital.

Physicians from twelve hospitals in Madison, Milwaukee, Wausau, Appleton, Green Bay, and LaCrosse have actively supported this venture. From the first a multidisciplinary approach using the expertise of head and neck surgeons, radiotherapists, nurses, dentists, social workers, and rehabilitation specialists was employed to provide continuing care of the patients. A clinical nurse specialist coordinated patient care in local communities by working with visiting nurses, local physicians and dentists, the patients, and their families. The five-year NCI funding for this pilot project is now ending, but the major activities will be continued by the physicians and institutions presently active in the Network.

Each year about 33,000 Americans (4% of all malignancies) develop cancer of the head and neck. In Wisconsin there are about 619 cases each year; almost 80% of these are treated at Network hospitals. Of those treated, 35% have cancers of the oral cavity, 27.5% of the larynx, 15.5% of a major salivary gland, and 12.4% of the oropharynx. Detailed information is being collected on the 1700 patients treated to date. Each is being closely followed, at first monthly and later less frequently.

Analysis of this data shows that 65% used both alcohol and tobacco, another 5.5% just tobacco, but only 4.7% had used neither. The data also confirms the knowledge that most cancers of the head and neck area do not respond to chemotherapeutic drugs, for 43% were treated by surgery alone, 31% by radiotherapy alone, but only 0.7% by chemotherapy alone. A combination of surgery and radiotherapy was used for another 18% and other combination therapy for 3.2%.

Because data on such a group of patients have never been collected before, this portion of the Network activities will continue to be funded by NCI. This will provide more information about survival, treatment success, and quality of life achieved by treatment and rehabilitation.

Education also has been an important function of the Network. Members have talked to many lay organizations and displayed an exhibit and distributed educational material at many shopping centers, conferences, and fairs. They also have given lectures, conducted seminars, and consulted with many medical professionals in the state. A special goal has been to help everyone understand the importance of prevention and early detection.

In June a state of the art conference for Midwest physicians was held in Madison. A distinguished faculty of the Clinical Science Center staff; Drs Stanley V Hoover and George A Sisson of Northwestern University School of Medicine; Dr John M Lore, Jr, of the State University of New York at Buffalo, School of Medicine; and Dr Emanuel M Skolnik of the University of Illinois, Abraham Lincoln School of Medicine, discussed difficult areas of pathologic diagnosis,

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

methods for treating advanced disease by both surgery and radiotherapy, and special procedures for reconstruction of massive defects of the face and neck and rebuilding of the glottis and voice box.

A major project of the demonstration networks was the development of *Management Guidelines for Head and Neck Cancer*. This book contains basic background information on characteristics and care of head and neck cancers. It also can be used as a checklist of steps which are customarily taken and considerations involved in the management of these cancers.

The first section is a general discussion of head and neck cancer sites. Especially valuable is the discussion of common departures from sound management with recommendations of steps for their prevention. Detailed management guidelines are given for carcinoma of the oral cavity, oropharynx, larynx, hypopharynx, cervical esophagus and trachea, nasopharynx, nasal fossa and paranasal sinuses, major salivary glands, and the neck with undetected primary.

This manual is presently being revised and copies can be obtained by writing Dr James Brandenburg, F4/270, Department of Otolaryngology, Clinical Science Center, 600 Highland Avenue, Madison, Wis 53792, or the Division of Cancer Control and Rehabilitation of NCI, Bethesda, Md 20014.

—DOROTHY J BUCHANAN-DAVIDSON, PhD
Science Writer

A Tribute to Doctor Caldwell

On page 32 there appears a tribute to the late Dr William Caldwell who had served the Wisconsin Clinical Cancer Center as associate director.

Mark Your Calendar Now

Midwest Cancer Seminar, September 20-22, 1979, Madison, Wisconsin. An outstanding international faculty will present practicing physicians with current knowledge about the screening, diagnosis, and management of major malignancies, emphasizing the practical application of new methodologies to the management of GI, GYN-GU, HEMATOLOGIC, and LUNG cancers.

Midwest Oncology Nursing Conference, Assertive Responses to Ethical Issues in Cancer Nursing, September 24, 1979, Madison, Wisconsin. Ethical issues nurses encounter in caring for persons with cancer, how to respond assertively when intervening on behalf of patients and their families, and values of family-centered approaches to living with cancer will be discussed.

Details in the YELLOW PAGES. ■

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CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
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Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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8-3921 (Y587A)

Overweight may not always be simple... complications can develop*.

Complicated or not...

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(diethylpropion hydrochloride NF)

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A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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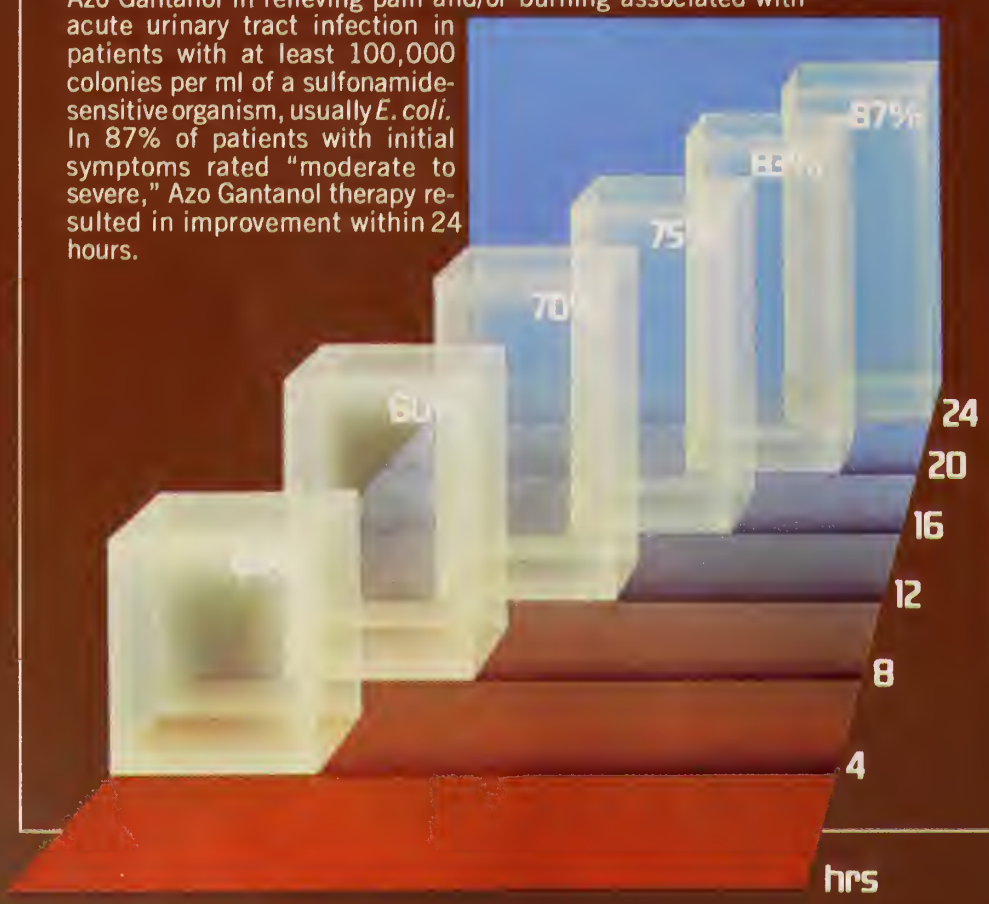
In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli.* In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain **for the pathogens**

Before prescribing, please consult comp uct information, a summary of which foll

Indications: In adults, urinary tract infec complicated by pain (primarily pyelonep pyelitis and cystitis) due to susceptible (usually *E. coli, Klebsiella-Aerobacter,* S *coccus aureus, Proteus mirabilis,* and, quently, *Proteus vulgaris*) in the absen obstructive uropathy or foreign bodies. **fully coordinate *in vitro* sulfonamide se tests with bacteriologic and clinical res aminobenzoic acid to follow-up culture increasing frequency of resistant organi the usefulness of antibacterials includi fonamides.** Measure sulfonamide blood variations may occur; 20 mg/100 ml sh maximum total level.

Contraindications: Children below age 1 fonamide hypersensitivity; pregnancy at during nursing period; because Azo Gan tains phenazopyridine hydrochloride it dicated in glomerulonephritis, severe h uremia, and pyelonephritis of pregnan disturbances.

Warnings: Safety during pregnancy not Deaths from hypersensitivity reactions, tosis, aplastic anemia and other blood have been reported and early clinical s throat, fever, pallor, purpura or jaundic dicate serious blood disorders. Frequen urinalysis with microscopic examination ommended during sulfonamide therapy

Precautions: Use cautiously in patients paired renal or hepatic function, severe bronchial asthma; in glucose-6-phosph dehydrogenase-deficient individuals in dose-related hemolysis may occur. Ma adequate fluid intake to prevent crystal stone formation.

Adverse Reactions: *Blood dyscrasias* (a ulocytosis, aplastic anemia, thrombocy leukopenia, hemolytic anemia, purpura thrombinemia and methemoglobinemia *reactions* (erythema multiforme, skin e Stevens-Johnson syndrome, epidermal urticaria, serum sickness, pruritus, ex dermatitis, anaphylactoid reactions, p edema, conjunctival and scleral injecti sensitization, arthralgia and allergic m *G.I. reactions* (nausea, emesis, abdom hepatitis, diarrhea, anorexia, pancreati stomatitis); *CNS reactions* (headache, neuritis, mental depression, convulsion hallucinations, tinnitus, vertigo and in *miscellaneous reactions* (drug fever, c nephrosis with oliguria and anuria, per nodosa and L. E. phenomenon). Due t chemical similarities with some goitrog uretics (acetazolamide, thiazides) and glycemic agents, sulfonamides have ca instances of goiter production, diuresis glycemia. Cross-sensitivity with these exist.

Dosage: Azo Gantanol is intended for t painful phase of urinary tract infections *adult dosage:* 2 Gm (4 tabs) initially, t (2 tabs) B.I.D. for up to 3 days. If pain causes other than infection should be s After relief of pain has been obtained, treatment with Gantanol (sulfamethoxa be considered.

NOTE: Patients should be told that the dye (phenazopyridine HCl) will color th

Supplied: Tablets, red, film-coated, ea ing 0.5 Gm sulfamethoxazole and 100 phenazopyridine HCl—bottles of 100 a

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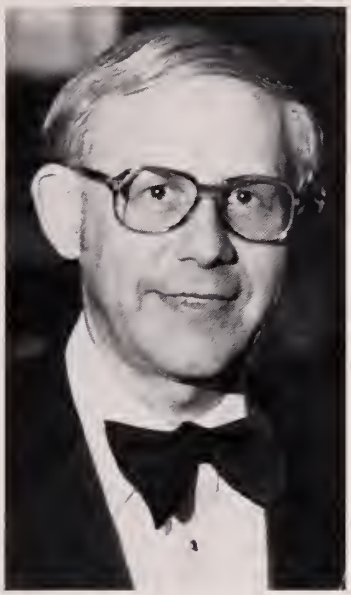
President Treffert . . .

Report to the House of Delegates as President-elect



We must enhance the image of medicine in the eyes of the patient and the public

In his first annual report of The Northern Hospital for the Insane, now Winnebago Mental Health Institute, Dr Walter Kempster, in 1876, remarked:

> *The results attained in the past one hundred years are certainly gratifying, and should stimulate us to carry forward the good work, constantly endeavoring to advance the interest of the people in whose cause we are all engaged, so that, when the record of the next hundred years shall be written up, it may be said of us, that our eyes were not altogether blinded, or that, with the light we had, our opportunities were not unimproved.*

That 100 years has passed now. Did we leave our opportunities unimproved? Were our eyes altogether blinded?

I think not.

What was the plight of the mentally ill in this state 100 years ago? That is what a visiting committee found here in Wisconsin in 1873:

> *Men and women unable to take care of themselves in pens with loose straw for beds and only a blanket to cover their naked bodies. In some jails the straw was changed daily, but in others clean straw was put in only once or twice a week. In one county an insane man and an insane woman were found nude, covered with their own excrement, huddled in a pile of straw above a pig pen. In another county the mentally sick persons were locked in a room which had not been cleaned for years. A sick woman was found in a dark cell in the cellar of a county jail. She received her food through a hole in the floor, like a wild animal receiving food from its keeper. A man was found in a cage in one jail with only one corner high enough for him to stand erect. An apparently blind, bright boy was found in a cell where his mother was chained to the floor. Inmates frequently killed each other and black eyes and bruises were evidence of fights and abuse of the keepers.*

Much has changed in 100 years in psychiatry. And a similar tale of human compassion, concern and work by our profession is repeated as well in every other specialty of Medicine:

. . . Mental hospital populations have dropped from 575,000 in 1955 to less than half that number in 1979. Length of stay is measured in days rather than months or years.

. . . Death rate from coronary heart disease fell by one third between 1968 and 1976.

. . . Life expectancy for a person born in 1977 rose from 72.5 years in 1975 to 73.2 years in 1977.

. . . Cancer death rate for persons under 45 years of age dropped from 21.8 per 100,000 in 1950 to 14.7 in 1976.

. . . Infant mortality dropped from 16.1 per 1000 live births in 1975 to 14.7 in 1977.

. . . Of the 13 leading causes of death in the United States, 8 had lower rates in 1977 compared to 1976. Three of those that did show increases—accidents, suicide and homicide—were not disease related.

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, May 10-12, 1979 in Milwaukee.

The record goes on and on. But in short, we in the Medical Profession have much to be proud of for what has happened these past 100 years, and for what continues to happen year after year.

That's the first thing I hope to be able to do in the year ahead as your President:

1. Highlight our successes

In our practices we encourage our patients to be assertive. We talk about an "affirmation experience"—the ability to point toward the best in ourselves and accept credit for same. Our profession needs to be more assertive and needs an affirmation experience of our own. Not as a Madison Avenue public relations job, but as an honest, forthright and accurate reminder to our patients and to ourselves about what has been accomplished, what we do have as a system of care in this country, what is being done, what remains to be done and what the costs are attendent to those accomplishments and those aspirations. In short, we have been simply too modest and not innovative or assertive enough about our profession and its strengths. Not that there are no problems, nor any weaknesses, but that surely there are not only problems nor only weaknesses.

Let me outline some of the other things I would like to accomplish in the year ahead.

2. Delegate, not relegate or abdicate

In the complex area of health care, which is viewed increasingly as a right, many forces come to bear, necessarily, in putting a viable healthcare system together. Planning, evaluating, monitoring, and even auditing all come with such a gigantic effort as health care has become. Others join the physician not only in planning health care, but in delivering it as well—paraprofessionals, physician extenders, and other practitioners/clinicians. It is appropriate that the physician delegate certain responsibilities to allied professionals who also bring skills and talent to the treatment effort. But there is a crucial difference between delegating, in which one assumes ultimate responsibility; relegating, giving to others that which one does not like to do, and abdicating, forfeiting responsibility altogether for certain tasks.

As physicians we are often so busy doing the urgent things that we forget to do the important things—like planning, like maintaining ultimate responsibility, and like delegating rather than relegating or abdicating. Health planners, for example, are often persons who know the cost of things but do not know the value of things. One of our important things, on behalf of our patients, is to continue to point to the value of things, not only the cost of things, in a truly responsive and humane system of health care.

3. Continue to be legislatively involved

Oliver Wendell Holmes, in his medical essay "The Young Practitioner," advises "do not dabble in the muddy sewer of politics." Yet, I agree with Arnold Toynbee when he writes: "The 20th Century will be remembered chiefly not as an age of political conflicts and technical inventions, but as an age in which human society dared to think of the health of the whole human race as a practical objective." That being the case, there is no such thing as keeping out of politics. The practice of medicine, and its availability to patients, will be decided as much on the floor of the individual legislatures and Congress as it will be in the research laboratory. Part of our effort needs to be directed to legislation, as well as technology, for clinical input is needed as desperately in the political decision-making arena as in treatment settings or laboratories. Here again, busy as we are with urgent things, we must also be involved with important matters of creating, giving input, and helping pass legislation on behalf of our patients, and maintaining a responsive, responsible system of care.

As physicians, we still maintain a good credibility with our patients. We, likewise, maintain a good credibility with legislators. The Physicians Alliance, I feel, has made an enviable record in establishing and maintaining a credibility with legislators. The Alliance reliably and conscientiously seeks out legislators to appraise them of our position and postures on bills. Recently, though, increasingly legislators seek out the Alliance for Medicine's views, insights, and support in a whole variety of relevant legislation on important public policy questions. The range of legislation that the Commission on Governmental Affairs considers each month is broad and wide, extending far beyond self-serving or provider-oriented legislation. Whole new arenas of legislation emerge as new technology develops, public policy needs evolve, and as the legislator and the medical profession seek a "reasonable middle grounds" in a whole variety of areas where law and medicine necessarily interact.

One piece of legislation of somewhat parochial concern, perhaps, that I would like to see SMS help shape this year is a Mental Health Act which more humanely balances clinical realities with legal rights than does the present Mental Health

Act in this state. In Wisconsin persons continue to "die with their rights on," situations where scrupulous concern for the patient's rights overshadows reasonable concern for the patient's life. We need a law that not only meets constitutional muster but meets humane muster as well. Our present Mental Health Act fails to meet humane muster.

Thomas Dooley, in a letter to Dr William Snively in 1958, said: "Politics, like clouds and other passing things, quickly skud by. The terrors of disease are always with us. Here is a challenge. It is flung at each of us individually. The response is not the job of government alone. A government can only go so far. It will never replace the individual citizen's sense of responsibility for those in the world "who ain't got it so good."

Each individual physician must continue to be legislatively involved, not for the survival of a profession, but toward a reasonable and useful system of care, public and private, for our patients.

4. Rearrange our sidewalks

At Winnebago, whenever we would build a new building, having listened to the expert opinion of the sidewalk consultants as to where the sidewalks to the building ought to be, and having put expensive sod between those expertly placed sidewalks, after the building was opened persons using the building would walk across the sod and rarely use the sidewalks. What we do now at Winnebago is put sod all around new buildings that we build, lay no sidewalks, wait one year, and then put the sidewalks where the pathways have naturally developed, over the sod by persons using the building. Our sidewalks get more use that way.

Part of our task in the year ahead is to rearrange our sidewalks to the healthcare system of this state, paying attention to the natural pathways that develop, newer, shorter, and more direct paths to care than those we may be accustomed.

Part of rearranging our sidewalks may be more effort in prevention rather than just in treatment. Prevention and wellness are not new discoveries. The Yellow Emperor, 3000 years BC, praised the physician "who did not treat those who were already ill; they instructed those who were not yet ill . . . the superior physician helps before the early budding of the disease. The inferior physician begins to help when the disease has already developed. The skillful doctor treats those who are well but the inferior doctor treats those who are ill. The good doctor pays constant attention to keeping people well so that there will be no sickness. The able doctor acts before sickness comes." Yet, perhaps we do need to balance that equation somewhat differently between our efforts in treatment and our efforts in prevention. Some of our prospective disease detection devices and indices can be put to good use and we have some expert examples of such programs right here in our own state. Likewise, our sidewalks may be rearranged somewhat by more "holistic" concerns. Again, holistic medicine is not a new discovery, but rather, a re-attention of our concern toward a balance between mind, body, and soul. While not a new idea, again a useful reminder that maybe we need to rearrange our schedules a bit more toward holistic concerns. We need to package our profession in a language the public can understand, accept, and apply. Whole professions have died or flourished because the language was good or bad. We need to send our best communications forward to the press, the media, and to the public, not as a hype effort, but as a way of translating what we know into a language which can be properly used and applied. From our patients we can often learn and use that language. I once asked a little boy who came into our hospital why he was there and he said, "Because I had a nervous breakdown." I asked him what a nervous breakdown was, and he said, "A nervous breakdown is when nobody loves you." That may be simplistic, or even corny, in the eyes of some people, but to other youngsters, adolescents, and a whole variety of other lonely people, such an interpretation carries more about some kinds of psychiatric problems than a lofty tome or a complicated videotape.

5. Peer review in policing our profession

If we are to attain or maintain credibility with the patient population we serve, and with the public so interested in what we do, we need to continue our already vigorous efforts in the area of peer review and policing our profession. To the extent that we are a profession that in no way supports quackery or cultism, exploitation or rip-off, featherbedding or greed, we enhance the image of medicine in the eyes of the patient and the public. Medicine is at times an inexact science, but it is not so inexact as to be able to absorb within its inexactness quackery, exploitation, rip-offs, or incompetence. While there clearly is wide latitude in styles of practice and patterns of professionalism, we need not be so

understanding of each other, as peers, so as not to demand a high standard of performance, integrity, and ethics of each of us.

Peer review will intrude into some of the sacred areas of schools of thought, styles of practice, and professional persuasions. We will need to be aware of cost:benefit ratios, effectiveness, and accountability, and must be willing to separate out, in terms of third-party pay, that which is essential compared to that which is clearly elective. Doing what we can to deal with one charlatan, one rip-off artist, or one incompetent practitioner who ought not to be practicing, does more in the eyes of the public than all the press releases we might send, ads we might buy, or the documentaries we might produce. It is a delicate but necessary area for us to tread in, not lightly, but vigorously, fairly but firmly, and bravely and knowledgeably. I feel the State Medical Society of Wisconsin already has done a great deal vigorously, firmly but fairly, and we need to perpetuate that activity so well already under way in peer review and monitoring of professional ethics.

6. Listen to the little Princess

An important insight for me, and I think for our profession, comes from a book called "Many Moons" by James Thurber. There are many useful works in medicine, to be sure, that each physician ought to read and be familiar with for his or her specialty. But I feel that no physician should practice medicine or a particular specialty without regularly re-reading "Many Moons."

Many Moons is a story about a little Princess, and the Princess is so sick that she is going to die. The King calls in a doctor to examine the little girl. The doctor says, "King, I'm sorry, but the little girl is so sick she is going to die unless you can grant her a wish and then she will recover." So the King, with all of his gross national product, concludes, "Hey, that ought to be simple! What would you like, Honey?" And the little Princess says, "Well, Daddy, when I lie in bed at night and look out the window up into the sky, and I see the moon, it is so very pretty. I would like the moon for my very own."

Of course, the King, in spite of his gross national product, is a little astounded by the magnitude of the request, so he calls in his royal consultants (and we have all kinds of royal consultants: our computers, our learned advisors, and our presidential task forces). The first royal consultant says, "King, everybody knows, and it has been scientifically proven that the moon is 5000 miles away, is made out of copper, and is larger than this whole palace." The second royal consultant states, "King, everybody knows, and it has been scientifically proven chi^2, that the moon is 10,000 miles away, is made out of bronze, and is larger than this whole kingdom. Everybody knows that!" The third royal consultant says, "King, with all deference to my learned colleagues in those other professions, the moon is actually a million miles away, is made out of asbestos, is flat as a penny, and is pasted up in the sky. Everybody knows that!"

Now the King was very confused by these conflicting expert opinions, and he knows that his little girl is going to die. He calls in the Jester to cheer him up. But instead of cheering him up, the Jester says "Hey, King, your royal consultants, your computers, your presidential task forces, are very smart people, but has anybody asked the little girl how big is the moon, or what is it made of, or how far away is it?" (Has anybody asked mentally ill patients about what the image of psychiatry is?) So the King says, "No, but I will ask her." "Honey, how big is the moon?" The Princess says, "Daddy, it's not very big. If I lie in bed at night and hold up my thumb I can just blot it out. It's about as big as the end of my thumb." "How far away is it?" the King asked, "Not very far. It gets caught in the trees out there at night." And, "What's it made of?" "Why, silly, it's made of gold. Everybody knows that, because it's yellow."

So the King summons his royal goldsmith and they make a little gold moon and hang it around her neck, and she immediately begins to recover. However, evening is coming and the King knows that the little girl is going to look up at the sky and look down at her neck and say, "Hey, Daddy, you tricked me. You said you gave me the moon, but you just gave me a phony one, because there it is still up in the sky. You're a fraud. I can't trust you anymore."

Now the King doesn't know just what to do, so he rings for his royal consultants to tell him what to do. The first says, "King, why don't we put black velvet all over the castle so the little girl won't see the moon up in the sky?" The second suggests sun glasses, or maybe even moon glasses for the little girl. The third suggests fireworks off in the distance to distract her attention.

By that time the King was a little smarter and he turned to his Jester, and he says, "Now what am I going to do?" The Jester says, "Well, King, your advisors, your computers, your royal consultants, and your presidential task force are very wise people. They certainly have lots of credentials, but has anyone asked the little Princess how is it possible to have the moon up in the sky and to have it around your neck at the same time?"

(Has anybody bothered to ask the mentally ill what they think we should do about mental illness?) So the King says, "No, but I will ask her." So he says, "Honey, how is it possible to have the moon up in the sky and have it around your neck at the same time?" "Silly, Daddy, that's a stupid question. That's the second stupid question you have asked me today. If I lose a tooth, a new one comes, and if the unicorn loses a horn, a new one grows, and every morning outside the window the gardener cuts the flowers and the next morning there are new ones there. Surely the sky looking down on a little girl who is so sick that she is going to die can give her the moon and grow a new one so she might recover."

At this point the little girl gets very sleepy and falls

asleep. The Jester tiptoes over to the window and looks up at the moon and winks, and the moon winks back.

"Listen to the patient, he is telling you the diagnosis," I learned, and you learned, in medical school a long time ago. Before we run a national study on the impact of medicine on patients, or appoint a task force, or create another Presidential Commission on something or other, we ought to ask the little Princess, our patients, what they think is the cause of their difficulties, and what suggestions they might have as to what to do about them. Before we run to the lab, the computer, the CAT scanner, or whatever, we need to continually be reminded to listen to the little Princess, whether that is in terms of individual diagnosis or a system of care in itself.

7. Forget not why we are enfranchised

Perhaps a significant problem with our profession, or any other profession, is that at times, because we are busy with urgent things, we forget why we exist at all. To attain, sustain, and maintain our image, our credibility, and our usefulness, we need to remember why we exist at all. When we do that, all the other things I mentioned so far come into place quite nicely and almost automatically.

There is a motto above the door of the oldest psychiatric hospital in the world near Paris. It reads: "To cure sometimes; to help often; to comfort always." In our technology, in our industry, and in our knowledge, we must remember the balance between seeking a cure and comforting the patient. Likewise it is important, it seems to me, that we remember the following, with which I would like to close my presentation:

Once upon a time there was a little village by the sea by a treacherous strait where ships would regularly wreck, be smashed and sink. The survivors of these shipwrecks would wander into the village, frightened, hurt, confused, alone, and in need of care. The townspeople saw these survivors, were compassionate, and tried to help in any way they could. They decided that what would really be nice would be to set up a little shack by the seashore to help the survivors. They did so, and they called it a Survivors Sanctuary. It was unpretentious but warm, modest but caring, simple but comforting.

At first it was staffed by volunteers, but they soon tired and a staff was hired. It was a busy place as more and more survivors—hurt, tired, and frightened—found their way to a place that helped them. Some of the survivors with broken bones or cuts or bruises were healed and cured. Some others, more seriously hurt, were at least helped but all were comforted.

As the Sanctuary grew, so did the staff. As the staff grew, so did the expenses. As the expenses grew, the townspeople organized a board of directors. The board hired an executive director. The executive director hired an assistant. The assistant organized a ladies auxiliary. The auxiliary had bake sales and benefits and raised money. Soon they had more money than was needed to run the Sanctuary, and they established a building fund because the little shack, modest as it was, didn't really speak well of their efforts and their status. They built a new Sanctuary (which they now called Survivors Center) high up on a bluff overlooking the strait. It was a beautiful view. They put in drapes, paneling, paintings, and carpeting wall-to-wall. It was a magnificent edifice.

Persons from other towns would go by the bluff and see the magnificent structure perched up on the hill, and they would inquire how they too, might set up Sanctuaries for their survivors. The director, the assistant and the board, as well as the staff, spent many hours explaining to other towns how they too could set up such a place. The staff would travel to these distant communities and help other towns set up Sanctuaries.

As other towns set up Sanctuaries soon there were sufficient such that an organization of Sanctuaries was started, convened, and drew up bylaws and a constitution. More and more Sanctuaries developed, such that the government set up a Section on Sanctuaries, then a Bureau, then a Division, and finally a Department. Standards and regulations were promulgated. At last, Sanctuaries were surveyed, approved, and accredited.

The staff meanwhile, already busied with helping other towns set up Sanctuaries of their own, and busied with meetings and standards and accreditation visits, transcended their involvement with the survivors and how to help them and began to inquire about the causes of shipwrecks, the safety of straits, the impact of shipwrecks on society, and soon wrote position papers outlining public policy over against straits, transportation, and safety. They inquired into the whole matter of societal fabric and transportation systems in general.

Meanwhile, because they were busied with these important matters, the staff and the board, and the executive director, and the auxiliary hardly noticed that fewer and fewer survivors were coming to the Sanctuary. It was a long walk up the hill, and when the survivors did come they were wet, dirty, and muddy. They got sand on the carpets. A place was set aside for the survivors downstairs, in a section that was maintenance-free, while the board, the director, the assistant, the staff, and the auxiliary had offices upstairs, where the carpeting, the paneling, and the paintings could be properly preserved.

As fewer survivors came, they again wandered about in the community—frightened, hurt, confused, alone, and in need of care. But while the staff didn't notice, some of the other townspeople did. And, they decided that what would really be nice would be to set up a little shack by the sea shore to help the survivors. And they did so. Once again the survivors came to the simple shack, where some were cured, some were helped, but all were comforted.

The story goes on and on . . . unless we don't let it. ■

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Past President Levin . . .

Report to the House of Delegates as President

With these accomplishments . . . "We must be doing something right!"

A year ago, in assuming the presidency of our Society, little did I know that I needed the serenity of the sphinx, the courage of General Patton and the wisdom of Solomon. Today, the moment of truth has arrived, the time to compare the many enthusiastic dreams with the actual accomplishments. At that time, I proposed that we use Education, Communication and Participation in a triple attack upon the problems facing the physicians in Wisconsin:

EDUCATION to develop a greater social, civic and political awareness among physicians.

COMMUNICATION to better tell our patients, our legislators, and the public of our needs, desires, and knowledge.

PARTICIPATION to change our attitudes and priorities, so as to become involved in all elements of society, the market place, and politics alike.

My predecessors have sometimes commented that a year's presidency is hardly enough time in which to accomplish much, least of which change. However, change is as inevitable as the passage of time, and the capacity to change is a good measure of an active mind. In this respect, I have noted that the pulse of activity in the State Medical Society is quick and strong. In support of this observation, let us briefly review .ome of the accomplishments and new developments of the past year, to show how our goals, yours and mine, are being achieved through education, communication, and participation. Among the "top twenty of the hit tunes" of accomplishment are:

1. Our Health Planning Commission has established a formal Physicians Planning Network to involve local physicians in local health planning activities, develop policy on health planning issues and influence planning decisions at every level. Nearly 200 doctors of medicine are now directly involved in this activity, including development of rules relating to certificate-of-need and decertification.

2. SMS staff assistance is now available to any County Medical Society willing to undertake new efforts to help Wisconsin physicians become visable and respected proponents of health maintenance, illness prevention, and the effective use of the healthcare system.

3. The Physicians Alliance Division has given birth to a socioeconomics unit to deal with the costs of medical practice, third-party relationships, and research into physician economics.

4. Two special conferences have been held to train physicians as well as staff in negotiations skills and their application to medical practice and governmental relationships.

5. Our Commission on Continuing Medical Education has produced this annual scientific session, seven educational seminars in various outstate locations, started working relationships with WisPRO, and accredited 42 hospitals, 25 specialty societies, and one county society as capable of offering continuing medical education programs for credits acceptable to licensing or certifying bodies.

6. Three weeks ago we sponsored a conference on Women's Health Issues . . . probably the first of its kind . . . and it attracted 427 women from all parts of the state. This was a most

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, May 10-12, 1979 in Milwaukee.

special and serious conference. The report of its discussions deserves the careful attention of every practicing physician. [A summary of the report appears elsewhere in this issue.]

7. Last fall our communications department and the Auxiliary took our Work Week of Health program to every public school in this state via television for five consecutive days. Our state's ten public television stations beamed a positive message about lifestyles to an audience estimated at half a million, bringing the best in medical advice direct from doctors to the youth of our state.

8. A more aggressive approach to professional self-discipline has been initiated by our Commissions on Ethics and Peer Review. They are giving widespread distribution to the public and physicians about this Society service for adjudication of complaints and, if necessary, the administration of discipline. Together, our county and state societies last year handled more than 500 such cases, more than 300 of which were formally adjudicated.

9. The Impaired Physicians Program of SMS has become fully established as a means of providing rehabilitative aid to physicians suffering from alcoholism, drug dependency, mental and physical illness, and senility. Physicians who are recovered alcoholics or drug dependents have been enlisted to help in these efforts.

10. Society members and staff now meet regularly with chief legislative leaders and state agency officials who have a growing awareness that SMS is willing and able to bring its special medical expertise to bear on proposed legislative or program policies affecting such diverse issues as mental health, eye care, brain death, environmental health, physician distribution, and patient advocacy.

11. The highly controversial Title 19 Medicaid "contract" has been renegotiated and totally revised into an acceptable agreement.

12. A uniform claim form has been developed and put into use in Wisconsin, not only for Medicaid but also for private insurance as well. Millions of copies are now being used. The labor and cost savings to physicians' offices are enormous.

13. Success was the name of the game for local physicians via WISPAC during the 1978 election campaigns. Physician-sponsored candidates chalked up victories in 100% of the Senate races and 91% of the Assembly races.

14. The specialty societies in Wisconsin now have major involvement in SMS affairs. Each section has voting membership in the Governmental Affairs and Health Planning commissions and participate as well in the Physicians Alliance and Continuing Medical Education commissions. In addition, SMS has inaugurated a plan to provide the specialty societies with administrative and executive services to assist in building cooperative relationships for the benefit of the entire profession.

15. The Resident Physicians Section has been activated; an Environmental Health Committee has been created; and the Jail Health Care Project is bringing public attention to the improvement of health conditions in our county jails.

16. Our Professional Liability Committee and representatives on the WHCLIP board of governors have been highly effective in containing malpractice premium rates, taking the first steps toward loss control, and making doctors aware of the facts about "countersuits" and "what to do if you are sued."

17. Cost containment is gaining physician acceptance and awareness. The recommendations of our Cost Evaluation Committee are coming before this House and deserve your support.

18. A new and highly practical approach to Medical Public Relations at the local level has been launched by our Public Information Commission and communications coordinator. The Society's packet of patient-doctor relations aids has won national attention as a model for helping physicians to improve their image as concerned and caring professionals.

19. Last fall we launched a new subsidiary corporation known as SMS Services, Inc. Its purpose is to provide a variety of personal and business services to physicians with quality and lower cost as the prime objectives. This unit also has launched a series of practice management seminars for MDs, their spouses and staffs, and finally . . .

20. Our toll-free line for members to call SMS headquarters in Madison has been a boon to communications. The number is 1-800-362-9080. Jot it down. Use it whenever you need it. In its first year of operation, more than 4,000 calls came into headquarters on that line.

These are some of the important accomplishments of our State Medical Society in the year 1978-79. A year ago, when I urged the members of our Society to get involved through education, communication, and participation, I had no idea that the results would be so dramatic. I am proud to have been part of the action. The real credit, however, goes to that ever-growing group of dedicated, hard-working, selfless, and faceless physicians and staff who have made it all happen. I am delighted to point out that with all this activity, the Society's membership—county, state and AMA—is the highest it has ever been and it is continuing to grow faster than ever before. As one of my colleagues said the other day. "We must be doing something right."

Before I turn the gavel and leadership of our Society to our new president, may I tender my thanks, with humility and sincere gratitude,

—To my dear wife, Beverly, whose encouragements and patience, understanding and tolerance were boundless, but end tonight!

—To Earl Thayer and Bernie Maroney, whose abundance of knowledge and technical skill made my tenure enjoyable (would you believe tolerable?).

—To my two stalwart, though tired associates, Dr Richard Strassburger and Dr Larry Frazin, whose responsibilities were increased by my extracurricular activities.

—To the articulate councilors of the State Medical Society, for their wisdom and moral support.

—To the loyal and enthusiastic chairmen of the many commissions and committees of the Society, and to their members for the endless efforts in pursuit of society excellence.

—And finally, to the associate and clerical staffs, whose endless efforts made the past year a pleasant happening.

It has always been an honor and privilege to be your president . . . and occasionally, it has even been a pleasure! ■

1979 Fifty-Year Club Members

1979 FIFTY-YEAR CLUB MEMBERS. Seated (left to right): Edward L Martineau, MD, Milwaukee; Frances A Cline, MD, Rhinelander; and Edward D Wilkinson, MD, Elm Grove. Standing (left to right): Nels A Hill, MD, Madison; William B Walton, MD, Madison; Jerry W McRoberts, MD, Sheboygan; Albert Popp, MD, Milwaukee; D Murray Angevine, MD, Madison; Robert A Frisch, MD, Milwaukee; Wiliam C Wojta, MD, Fond du Lac; William H Studley, MD, Milwaukee; Benjamin I Brindley, MD, Madison; and Earl C Quackenbush, MD, Hartford. The State Medical Society annually pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity. Thirty-four physicians were so honored at the Presidents Dinner during the Annual Meeting in Milwaukee. Those unable to attend and not pictured above are listed in the June BLUE BOOK *issue of WMJ.* (Staff photo by Ken Opin)

Summary Report, House of Delegates

State Medical Society of Wisconsin, May 10-12, 1979, Milwaukee

THE FOLLOWING constitutes the summary report of actions taken at the Annual Session of the House of Delegates, May 10-12, 1979, replacing the formal printing of reports and detailed proceedings because of the great expense involved. Resolutions and reports were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the content of a particular report or resolution.

Earl R Thayer
Secretary

THE HOUSE DELIBERATED 25 resolutions as well as reports of officers, the Council, commissions and committees of the Society. Refer to the March 1979 *Wisconsin Medical Journal* for abstracts of the resolutions and their sources. Following is the text of the House of Delegates reference committee reports (with additional text inserted where needed for meaning) and indication of action upon their recommendations by the House.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

● REPORT OF THE PRESIDENT. The committee recommends acceptance of the report of President Levin. [The full text appears elsewhere in this issue.]
¶Action: ACCEPTED

● REPORT OF THE PRESIDENT-ELECT. The committee recommends acceptance of the report of President-elect Treffert. [The full text appears elsewhere in this issue.] ¶Action: ACCEPTED

● REPORT J—*Physicians Alliance Commission.* The committee recommends acceptance of the report with deletion of the word "unified" in paragraph C on page 2. [This paragraph in the report listed as a goal an intensive membership recruitment and retention effort, and included the following sentence: "A strong, unified membership is the best mechanism to insure that medicine's voice is heard in the legislature, the bureauracy, and the executive office."] ¶Action: REPORT ACCEPTED AS AMENDED

● REPORT K—*Governmental Affairs Commission.* The committee recommends acceptance of the report. [The report was informational as to the status of legislative matters under study by the commission and its committees, and included a special edition of CAPITOL WEEK listing bills before the Legislature with SMS position, if any.]
¶Action: REPORT ACCEPTED

● RESOLUTION 12—*Equitable Risk Classifications in Medical Liability Premiums.* This resolution provides for State Medical Society of Wisconsin support of the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category. The committee recommends that it be referred to the Medical Liability Committee of the Physicians Alliance Commission for further study and the findings of that study be presented to the House of Delegates in 1980. ¶Action: REFERRED

● RESOLUTION 13—*Preferential Hospital Rates.* This resolution requests that the State Medical Society initiate discussions with representatives of the Wisconsin Hospital Association to explore the subject of preferential hospital rates. The committee recommends adoption of this resolution with the deletion of the following paragraphs:

> "RESOLVED, That the State Medical Society of Wisconsin oppose hospital charge arrangements granting unwarranted advantage to any group of patients; and be it further
> "RESOLVED, That the State Medical Society of Wisconsin adopt a policy urging all health care payors, government and private, to pay their equitable share of costs incurred by hospitals and other facilities; and be further"

[The remaining resolve after deletion of the above reads as follows: "RESOLVED, That the State Medical Society of Wisconsin initiate discussions with representatives of the Wisconsin Hospital Association, exploring the subject of preferential hospital rates and recommending remedial and preventative measures."]
¶Action: RESOLUTION ADOPTED AS AMENDED

● RESOLUTION 14—*Health Care Insurance and AMA Policy.* This resolution provides for State Medical Society endorsement of the AMA House of Delegates actions concerning health care insurance and requests that the AMA Board of Trustees be informed of this endorsement by written communication from the Speaker of the House. The committee recommends adoption of Resolution 14. ¶Action: Motions from the floor had the effect of (1) amending the first resolve to read "that the State Medical Society of Wisconsin House of Delegates endorse the actions of the AMA House of Delegates," and (2) amending principle 4 of the

AMA action by addition of the words in italics: "A program developed pursuant to these principles should be administered at the State level with national standardization *of insurance policies* through Federal guidelines."

● RESOLUTION 15—*Second Opinions.* This resolution provides that the State Medical Society endorse the AMA statement on second opinions and accept it as SMS policy. The committee recommends adoption.
¶Action: Resolution adopted together with the following policy statement:

"Recognizing that the advisability of surgery or other specific therapy can be a matter of opinion, the House of Delegates of the American Medical Association and of the State Medical Society of Wisconsin (1) affirm the right of a patient or a physician to seek a second opinion freely from any physician of his/her choice; (2) oppose the concept of mandatory second opinions or the imposition of financial penalties by a third party payor for not obtaining a second opinion; and (3) support the concept that, when a second opinion is required by a third party, that second opinion should be at no cost to the patient."

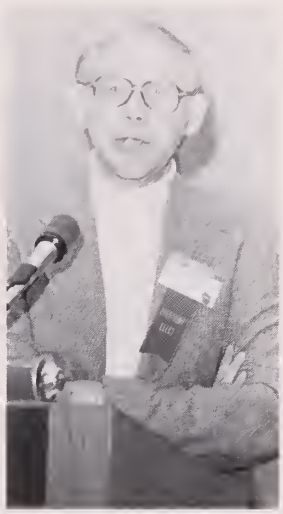
● RESOLUTION 16—This resolution recommends that the Speaker of the House of Delegates appoint a committee to review activities of the Wisconsin Physicians Alliance and advise SMS members of its findings. The committee recommends adoption of Resolution 16 with deletion of the words "and wages" from paragraph 4 (2). [The resolve with this deletion requests review and report of findings relating to: (1) meeting the House of Delegates and Physicians Alliance goals; (2) expenditures relating to specific activities within its budget; and to (3) recommend any changes needed to continue the Physicians Alliance as an effective tool with full support of the membership.]
¶Action: ADOPTED AS AMENDED

● RESOLUTION 17—*Clean Energy.* This resolution makes a number of suggestions to the AMA concerning issues related to clean energy. The committee recommends its adoption (and introduction to the AMA House of Delegates). ¶Action: ADOPTED

● RESOLUTION 18—*Restoration of Drinking Age to 21 Years.* This resolution provides for State Medical Society support of the restoration of the legal drinking age in Wisconsin to 21 years. The committee recommends adoption of this resolution with deletion of the words lined through in the second whereas: "The lower age has resulted in problems related to under-21 drinking, ~~including greater risks of alcoholism, an increase of automobile accidents and a rise in vandalism and real crimes;~~ and"
¶Action: ADOPTED AS AMENDED

● RESOLUTION 19—*Brain Death.* This resolution suggests that the Wisconsin Legislature be stimulated toward leaving the definition of brain death

Jules Levin, MD
President



Darold Treffert, MD
President-elect

Albert Motzel Jr, MD
Speaker

Duane Taebel, MD
Vice-speaker

Paul Haskins, MD
Chairman, Council

Eugene Nordby, MD
Treasurer

Harry Foerster Jr, MD
Chairman, Reports of Officers

Robert Madden, MD
Chairman, Resolutions and Amendments

George Flynn, MD
Chairman, Credentials Committee

Vernon Griffin, MD
Chairman, Finances

Earl Thayer
Secretary

Richard Ulmer, MD
Chairman, Reports of Standing Committees

to a duly constituted panel of experts working in continuum in that area. The committee recommends adoption of this resolution.

¶Action: After discussion from the floor, the motion to adopt lost and the RESOLUTION WAS REJECTED

● RESOLUTION 21—*Occupational Health.* This resolution states the State Medical Society's opposition to the reduction of occupational health staff in the Division of Health. The committee recommends adoption of this resolution with the addition of a fifth whereas, "the federal Occupational Safety and Health Administration has proposed a severe reduction in its financial support of Wisconsin occupational health consultive services," and addition of the words in italics in the resolve, "that the State Medical Society shall oppose the reduction of occupational health staff *and funding for* the Division of Health." ¶Action: ADOPTED AS AMENDED

● RESOLUTION 22—*Allied Health Care Practitioners.* This resolution requests State Medical Society support for "legislation or administrative rule action which would develop mandatory referral criteria and/or guidelines for allied health care practitioners in order to promote prompt and effective health care treatment for the citizenry and to protect patients from inadequate care." The committee recommends its adoption. ¶Action: By amendment from the floor, the word "mandatory" was deleted from the resolution.

● RESOLUTION 23—*Medical School Loss of Income.* This resolution requests that the Society contact Wisconsin legislators and Secretary of HEW Califano to protect the state medical schools from revenue losses which would result from a reduction in medical school enrollment. The committee recommends adoption. ¶Action: ADOPTED

● SUPPLEMENTARY REPORT OF COUNCIL, item 5—*Medical School Class Size and Cost of Education.* The committee recommends acceptance of the Council's position which states that it would be inappropriate for the State Medical Society to suggest limitations on the number of physicians being educated in Wisconsin schools and which supports the loan forgiveness program but takes no position on the amounts of tuition charged by either of the medical schools. ¶Action: ACCEPTED

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

● REPORT A—*Commission on Public Information,* outlines activities of the commission and delineates plans for the coming year. The reference committee commends the commission for its work and its success in generating positive publicity for physicians and the State Medical Society. It particularly commends the educational campaign on the Fetal Alcohol Syndrome that was promoted through the five major media centers in the state, and recommends adoption of this report. ¶Action: ADOPTED

• REPORT B—*Jail Health Care Committee,* outlines activities of the committee which coordinates the special effort to accredit Wisconsin county jails that meet minimum standards for the provision of quality medical services. The reference committee highly commends the Jail Health Care Committee for its work with 16 county jails in Wisconsin, encourages it to continue its excellent work, and recommends adoption of this report. ¶Action: ADOPTED

• REPORT C—*Committee on Mental Health,* outlines current activities of this committee which was reactived in the past year. The reference committee commends the efforts of the Mental Health Committee in providing input on policy development as it relates to psychotherapy provisions of the Medicaid Super-Rule and the recodification of Wisconsin's mental health laws, and recommends adoption of this report. ¶Action: ADOPTED

• REPORT D—*Commission on Health Planning.* We highly commend the commission for its extensive efforts at developing a comprehensive structure for physician involvement in the health planning process; urge the commission through the Wisconsin Physicians Planning Network (WPPN) to secure the cooperation of health planning agencies in submitting health plans and reports to the public with sufficient time for analysis and preparation for substantive response; commend the commission for its diligent work in involving more than 100 physicians in the rule development process for Wisconsin's decertification law; and recommend adoption of this report. ¶Action: ADOPTED

• REPORT E—*Commission on Mediation and Professional Ethics.* The reference committee commends the commission's efforts at implementing the Impaired Physician Program; urges the commission to continue its efforts to publicize that program and to continue its good work; commends the commission for its work on a grievance protocol that assures all parties to a grievance or dispute that the Society's mediation efforts will be fair and will incorporate the elements of due process and equal appeal rights; encourages the commission to implement its objective of distributing brochures on the Society's grievance procedure through physician offices; and recommends adoption of this report. ¶Action: ADOPTED

• REPORT F—*Committee on Maternal and Child Health.* The reference committee commends the committee for its informational campaign on the Fetal Alcohol Syndrome which has been successful in alerting women to the dangers of heavy alcohol consumption during pregnancy; encourages the committee to continue its support for the immunization of children and its program of injury prevention for children particularly with regard to the placement of child restraints in automobiles and school buses; and recommends adoption of this report. ¶Action: ADOPTED

• REPORT G—*Commission on Continuing Medical Education,* outlines its activities on accreditation and medical education programming over the past year. The reference committee commends the commission for its extensive efforts at accrediting hospitals, county medical societies, and specialty medical groups for continuing medical education programming; urges the commission to expand its excellent continuing medical education regional seminars to other areas of the state in addition to continuing its special seminar programming in Green Bay and Madison; and recommends adoption of this report. ¶Action: ADOPTED

• REPORT H—*Commission on Peer Review,* outlines its extensive efforts at reviewing physician practice patterns that have been referred to the State Medical Society by the Medicare intermediary and insurance carriers. The reference committee commends the commission for its thorough and impartial approach to practice pattern reviews; notes the Council's action to combine the Commission on Peer Review and the Commission on Mediation and Professional Ethics into a single commission entitled the Commission on Mediation and Peer Review; anticipates that the new commission will carry out both the functions of review for grievance purposes and review of practice patterns and will retain the distinction of these review activities as it carries out its responsibilities; and recommends adoption of this report. ¶Action: ADOPTED

• REPORT I—*Committee on Occupational Health,* outlines its activities over the past year and evidences its concern for the health and safety of Wisconsin citizens in the workplace. The reference committee particularly supports the position of the committee that simplified reports for work related injuries should be prepared and filed by physicians at no charge, and recommends adoption of this report. ¶Action: ADOPTED

• REPORT L—*Committee on Safe Transportation.* The reference committee highly commends the committee for its efforts at developing guidelines on (controlled) alcoholism and cardiac problems for school bus operators. [With reference to an item in the committee report relative to consideration of a report about psychoactive drugs and driving, its chairman, Doctor Weygandt, proposed a change of words in the following sentence: "Blood levels which would impair or inhibit functional competency have not been established; therefore, the Committee (on Safe Transportation) declined to suggest a ~~toxic~~ *driving impairment* level for any drug singly or in combination with each other or with alcohol."] The reference committee recommends adoption of the report with this amendment. ¶Action: ADOPTED AS AMENDED

• REPORT M—*Committee on School Health,* outlines its activities in the past year especially with regard to the state plan to serve handicapped chil-

dren. We commend the committee for its bold agenda for the coming year [workshop for physicians, school administrators, and school board representatives on regulations and responsibilities to provide appropriate education and health care; distribution of an AMA brochure on health education in schools; informing physicians of their obligations in identifying children with exceptional educational needs] and recommend adoption of the report. ¶Action: ADOPTED

● REPORT N—*Committee on Medicine and Religion.* We commend the committee for its important work and encourage it to pursue its priority objectives for the coming year, particularly its interest in sponsoring a special conference for clergy and physicians on the cancer residency program, and recommend adoption of this report. ¶Action: ADOPTED

● REPORT P—*Committee on Aging and Extended Care Facilities,* describes its work in developing guidelines on the responsibilities of physicians to patients in long-term care facilities. We commend the committee's success in making the physician visit requirement more flexible; urge the committee to continue its efforts so that physician visits to patients in long-term care facilities are required on the basis of medical need rather than an arbitrary period of time; and recommend adoption of the report. ¶Action: ADOPTED

● RESOLUTION 20—*Council of Information and Communications.* This resolution recommends establishment of a Council of Information and Communications that would have no formal meetings, but would establish a communications network with each hospital staff over a 30-bed capacity for the

COUNCIL AWARD
Howard Correll, MD

Chairman of the Council Paul Haskins, MD and Howard Correll, MD

Howard L Correll, MD, Arena, was awarded the highest honor of the State Medical Society —the Council Award—Friday evening, May 11, at the Presidents Dinner during the SMS Annual Meeting in Milwaukee. Paul S Haskins, MD, River Falls, in presenting the 43rd Council Award to Doctor Correll said: "while he was bluntly critical of deliberate incompetence in the profession, Doctor Correll was always tolerant of the sincere failure, acknowledging the intricacies of an imprecise art. To know him was to become more conscientious, more dedicated, and more involved in being a physician."

Doctor Haskins noted that throughout Doctor Correll's more than 30 years as a practicing physician and as a leader in organized medicine, he has displayed an integrity and intellectual curiosity unequaled by his peers.

Doctor Correll served as president of the State Medical Society of Wisconsin from 1975-1976 and as chairman of the Council in 1976-1977. During this time he steered the profession through a malpractice crisis, helped to develop an effective socio-economic branch, brought the critical issue of medical cost containment to the fore, and caused a reawakening of the true mission of organized medicine.

A native of Spring Green, Doctor Correll graduated from the University of Wisconsin Medical School in 1935. He served his internship at Ancker Hospital in St Paul, Minnesota and his residency at the University of Iowa General Hospital and Milwaukee County General Hospital.

Doctor Correll began his Milwaukee practice 39 years ago at the Clinic of Internal Medicine which he established in 1940. As part of their commitment to the group, all internists are required to spend 25 percent of their time in teaching and research.

Doctor Correll was president of the Medical Society of Milwaukee County and Surgical Care-Blue Shield. He also served as clinical professor of medicine at Marquette University School of Medicine and as coordinator of cardiovascular teaching and research there for 25 years.

In the early years when cardiology was first emerging as a discipline, Doctor Correll was a leader in its development. He established the first Wisconsin Conference on Work and the Heart in Milwaukee, a conference which won acclaim all over the United States, with many of its results still used today in the area of cardiac rehabilitation and work in heart disease.

Doctor Correll served on the Board of Directors of the Wisconsin Heart Association for ten years and as its president in 1954. He also has served as chief of staff at St Luke's and Milwaukee County General hospitals.

purpose of facilitating communication. The reference committee believes that the establishment of a communications network is best considered and implemented by the SMS Commission on Public Information, and recommends that Resolution 20 be referred to that commission for its consideration and that the commission consider mailing the SMS *Medigram* to all hospitals in Wisconsin regardless of bed capacity for the purpose of having it posted for physician information. ¶Action: RESOLUTION REFERRED

● SUPPLEMENTARY REPORT OF COUNCIL, item 2—*Nursing and Nursing Education*. The reference committee supports the Council's recommendation and strongly recommends that the Council communicate its support of nursing education at all levels including degree schools, diploma schools and schools for licensed practical nurses, to the legislature and appropriate state agencies.

¶Action: RECOMMENDATION ADOPTED

● SUPPLEMENTARY REPORT OF COUNCIL, item 6—*Physician Availability in Wisconsin*, calls for a reevaluation and study of the distribution and availability of physicians in Wisconsin with an emphasis on primary care. The reference committee strongly supports implementation of this recommendation and commends the Council for its interest in the serious problem of physician distribution in Wisconsin.

¶Action: RECOMMENDATION ADOPTED

● SUPPLEMENTARY REPORT OF COUNCIL, item 7—*Designation of "Physician Shortage" Areas*, recommends a study of the process by which physician shortage areas are designated and eligibility for Health Service Corps physicians is established. Because the number of National Health Service Corps physicians is increasing, the reference committee believes this study is essential and it recommends adoption and implementation of this recommendation. ¶Action: ADOPTED

● SUPPLEMENTARY REPORT OF COUNCIL, item 9—*Women's Health Issues Conference*, refers to the report to Wisconsin physicians that emanated from the conference. The reference committee agrees with the Council that the information contained in this report should be referred to the appropriate Society committees, and recommends that the Council report be accepted. ¶Action: ACCEPTED

SOME SPEAKERS AND GUESTS: 1. Ed McClain (D-Wausau), State Representative. 2. Roy Pfautsch, president of Civic Services, Inc in St Louis, Mo. 3. Joe Czerwinski (D-Milwaukee), State Representative and chairman of the Assembly Health and Social Services Committee. 4. Robert Hunter, AMA Board of Trustees chairman, and Frank L Jirka Jr, MD, AMA B/T vice-chairman. 5. Robert Durkin, administrator of State Division of Health. 6. Mrs Kenneth Smigielski, Milwaukee, president-elect of SMS Auxiliary. 7. Rabbi Manfred Swarsensky, Madison. 8. Pauline Jackson, MD, LaCrosse. 9. President Darold Treffert, MD, Fond du Lac; Past President Jules Levin, MD, Milwaukee; and President-elect Russell Lewis, MD, Marshfield.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

● RESOLUTION 1—*Unified Membership*, calls for an amendment to Article IV of the Constitution. Your reference committee reports to the House that the amendment has been introduced in timely fashion, and consistent with Article XIII of the Constitution it will lie over as presented for consideration and vote at the 1980 annual session.

¶Action: REPORT ACCEPTED

PRESIDENTIAL CITATION

Green Bay Area Free Clinic Physicians

President Jules Levin, MD; Richard Dresang, administrator of the Green Bay Free Clinic; and Robert Johnston, MD

In 1971, a Brown County internist and a University of Wisconsin Green Bay student working with the local health and social services department, recognized that a number of people were being denied Medicaid benefits in the county, yet they couldn't afford conventional health insurance coverage or services.

These two individuals realized the need for a free clinic that could provide medical services to this segment of the community whose economic status interfered with their access to adequate medical care.

After pursuing the idea with physicians in the community and obtaining their support, the Green Bay Area Free Clinic, Ltd was born in July of 1971.

Today, 76 physicians from the Green Bay area each volunteer several hours of their time each month to working in the clinic, or taking patient referrals at their offices on a free basis.

The State Medical Society of Wisconsin honored the volunteer physicians of the Green Bay Area Free Clinic, Ltd May 11 during the Society's 1979 Annual Meeting in Milwaukee. Accepting the Presidential Citation Award of the Society on behalf of the physicians at the clinic were Dr Robert Johnston of the Brown County Medical Society and Mr Richard Dresang, administrator of the clinic.

The Presidential Citation, given only at the direction of the Council, was presented by SMS President Jules D Levin "in recognition of the clinic's outstanding program for providing medical care to needy persons, and in appreciation of the support of the Brown County Medical Society and of the devoted services of the many volunteer physicians who help make free clinic care possible."

Since the clinic's inception eight years ago, Brown County physicians have been enthusiastic and active supporters of the clinic, giving freely of their time both in the delivery of medical care services, and in the management of the clinic. The clinic successfully provides direct medical services, including acute medical treatment, healthcare counseling, preventive medical services, and referral services on an outpatient basis to individuals and families at nominal or no cost to them.

"Our clinic has been cited as one of the strongest free clinics in the nation, not in terms of dollars perhaps, but in terms of physician support," says Richard Dresang, clinic administrator.

The Brown County Medical Society has a special review committee to serve the clinic in an advisory capacity and has encouraged physician members to be active participants in the clinic.

In 1978 the physicians at the Green Bay Area Free Clinic provided medical services to all age groups, for a total of 6,109 needy patients at a total cost of $5.55 per patient. Many persons received care at no cost at all to them, Dresang added.

Operating entirely on private funds, the clinic receives no federal or state subsidies.

"We depend entirely on contributions from service organizations, churches, and concerned individuals," Dresang noted. "Here, too, however, many physicians have lent us a great deal of assistance in securing funds for the clinic's operation."

"In this time of criticism of the cost of medical care and the charges by many people that physicians have an 'uncaring' attitude towards those persons who can't afford medical services, it's important to tell the story of what Brown County physicians are doing at the free clinic," Dresang said. "While these physicians don't ask for recognition, they are most deserving of it," he said.

SCIENTIFIC EXHIBIT AWARDS

The following scientific exhibits won Citation of Merit Awards at the 1979 SMS Annual Meeting:

FIRST: "Transoral Microsurgery with the CO_2 Laser," Columbia Hospital, Milwaukee.

SECOND: "Ambulatory Pain Strategies," The Medical College of Wisconsin and The Curative Workshop of Milwaukee.

THIRD: "Cerebral Evoked Potentials," Veterans Administration Hospital, Wood.

DEANS ACCEPT AMA-ERF CHECKS

Mrs Leslie Stone, Arnold Brown, MD; Edward Lennon, MD

Mrs Leslie H Stone (above, left) Oshkosh, state Auxiliary chairman of the American Medical Association's Education and Research Foundation, presented the deans of the state's two medical schools with checks at the May 10 House of Delegates session at the SMS Annual Meeting in Milwaukee. A check for $11,893.40 was presented to Dean Arnold Brown (above, center) of the University of Wisconsin Medical School, while Dean Edward Lennon (above, right) accepted a check for $14,106.43 on behalf of the Medical College of Wisconsin. The American Medical Association Education and Research Foundation is the only national philanthropic and fund-raising effort of the AMA Auxiliary. In Wisconsin, money is raised each year through several projects of the Auxiliary and contributions of Wisconsin physicians and their spouses.

- RESOLUTION 4—*Unified Membership,* also calls for amendment to Article IV of the Constitution, but additionally strikes the clause "who shall be members of the component medical societies." The reference committee was not clear as to the exact intent of the amendment. The committee reports that the proposed amendment has been introduced in timely fashion, and consistent with Article XIII of the Constitution it will lie over as presented for consideration and action at the 1980 annual session.

¶Action: REPORT ACCEPTED

- RESOLUTION 2—Support of American Medical Association, is recommended for adoption.

¶Action: RESOLUTION ADOPTED

- RESOLUTIONS 3, 5, and 6 dealing with *unified membership* are recommended for rejection on the basis that a constitutional amendment is before the House for action in 1980.

¶Action: RESOLUTIONS REJECTED

- RESOLUTIONS 7 and 8 relate to *polls, surveys and referenda,* including a request for review and interpretation of Article XI of the Constitution. Your reference committee recommends that these resolutions be referred to the new Council-created constitutional revision committee for consideration.

¶Action: REFERRED

- RESOLUTION 9 relates to the *Office of Treasurer and the Finance Committee of the Council.* Your reference committee recommends that this be referred to the constitutional revision committee for further study. ¶Action: REFERRED

WILLIAM BEAUMONT MEMORIAL LECTURE AWARD

Edward L Bradley, III, MD

Edward L Bradley, III, MD, an associate professor of surgery at Emory University School of Medicine, Atlanta, Georgia presented "Surgical Management of Acute and Chronic Pancreatic Disease" at the 1979 William Beaumont Memorial Lecture in Milwaukee May 12. Established by the State Medical Society in 1957, the William Beaumont Memorial Lecture is designed to present to members of the Society distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. The Lecture is given during the Scientific Plenary Session at the Annual Meeting each year in honor of Dr William Beaumont. A United States Army Surgeon, Doctor Beaumont in the early 1800s performed a series of experiments which laid the foundation of our knowledge of digestion. Leland C Pomainville, MD, Wisconsin Rapids, presented the award plaque to Doctor Bradley.

• RESOLUTION 24—*Medical Ethics*. Your reference committee agrees in principle with the intent that high ethical standards be maintained by Wisconsin physicians, and recommends adoption of the resolution with deletion of the words "personal and" in the final resolve, which would then read "that the Wisconsin Medical Schools be encouraged to place new and greater emphasis on professional ethics in the student curriculum."

¶Action: ADOPTED AS AMENDED

• REPORT Q—*The Council*. Your reference committee wishes to commend the Council for its informational report and recommends that it be filed.

¶Action: REPORT FILED

• SUPPLEMENTARY REPORT OF COUNCIL, item 1—*Resolution A* concerns medical organizational structure and calls upon the American Medical Association to study and make recommendations on alternative methods of organizing physicians so as to preserve their strength and unity as professionals. The committee recommends adoption of Resolution A and forwarding to the AMA. ¶Action: ADOPTED

• SUPPLEMENTARY REPORT OF COUNCIL, item 4, reports formation of an ad hoc committee to *review and update the Society's Constitution and Bylaws*. Your reference committee recommends approval of this action by the Council. ¶Action: APPROVED

• SUPPLEMENTARY REPORT OF COUNCIL, item 8, forwards to the House the report of the *Committee on Evaluation of the Delivery and Cost of Medical Care*. Your reference committee commends and recommends acceptance of that report which contains recommendations for cost containment in both the short and long range, and principles of implementation. Your committee further recommends approval of creation of a more broadly based committee to continue the study and implementation of its recommendations.

¶Action: RECOMMENDATIONS ADOPTED

• REPORT OF THE SECRETARY. Your committee recommends commendation of the Secretary and filing of the report for informational purposes.

¶Action: FILED

• STATUS REPORT ON 1978 HOUSE OF DELEGATES ACTIONS. Your committee recommends filing of this informational report. ¶Action: FILED

REFERENCE COMMITTEE ON FINANCES

• REPORT OF THE TREASURER, E J NORDBY, MD. We take note that reserves were reduced by nearly $46,000 in 1978 which was slightly less than what had been budgeted, but at the same time we realize the 1979 budget calls for a reversal of that by adding slightly more than $30,000 to reserves. The committee recommends the report be received. ¶Action: RECEIVED [See financial statements elsewhere in this issue.]

INTERSTATE TEACHING AWARD
Warner S Bump, MD

Robert Callan, MD and Warner Bump, MD

The Erwin R Schmidt Interstate Postgraduate Teaching Award was presented to Warner Smith Bump, MD, Rhinelander, by Robert E Callan, MD, Trustee and Vice-speaker of the Scientific Assembly of Interstate Postgraduate Medical Association of North America Friday evening, May 11 at the Presidents' Dinner. Named in honor of Doctor Erwin R Schmidt, who for many years was the chairman of the Department of Surgery at the University of Wisconsin Medical School and a former trustee of Interstate, the award is presented to a physician who has served the profession with distinction as a practicing physician and teacher. In presenting the award, Doctor Callan said: "Doctor Bump's long years of dedicated service to teaching medical students through the preceptorship program have embodied the spirit of Interstate which has as its sole purpose the advancement of the art and science of medicine through continuing medical education."

Attendance: 1427

Total attendance of the two-day scientific program, May 11-12, 1979 at the MECCA in Milwaukee was 1427, up slightly from 1978.

Registration of physician members was 949 (also up slightly from last year), while the balance consisted of 17 nonmember physician registrants; 21 physician guests; 238 technical exhibitors (more than double from last year); 50 scientific exhibitors; 80 interns, residents, and medical students; and 72 guests (certified nurses, physician spouses, and others) [down substantially from last year].

The three sessions of the House of Delegates had the following registrations: 130 first session; 133 second session, and 99 third session. There are 152 voting members of the House. ■

ELVEHJEM MEMORIAL LECTURE AWARD
Joseph J Barboriak, ScD

"Lipoproteins as Risk Factors in Coronary Heart Disease" was the title of a presentation made by Joseph J Barboriak, ScD, of Veterans Hospital in Wood, Wisconsin at the Elvehjem Memorial Lecture Saturday, May 12, at the SMS Annual Meeting in Milwaukee. Daniel K Schmidt, MD, Milwaukee presented Doctor Barboriak with the Elvehjem Memorial Award at the Internal Medicine Plenary Session sponsored by the Society's Charitable, Educational and Scientific Foundation. The Lecture was established in 1962 to honor the memory of Dr Conrad A Elvehjem, the 13th President of the University of Wisconsin and an international authority in biochemistry. It is designed to perpetuate Doctor Elvehjem's contributions to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians.

Staff photos by Ken Opin

THANK YOU

The reference committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done."

Reference Committee on Reports of Officers: MDs Harry R Foerster, Jr, Milwaukee, chairman; Gilbert H Stannard, Jr, Manitowoc; Milfred A Cunningham, Madison; Russell S Pelton, Ripon; Thomas A Hofbauer, Menomonee Falls.

Reports of Standing Committees: MDs Richard H Ulmer, Marshfield, chairman; G Daniel Miller, Oconomowoc; James N Moore, Madison; John J Beck, Sturgeon Bay.

Resolutions and Amendments: MDs Robert F Madden, Milwaukee, chairman; Charles S Geiger, Jr, West Bend; J D Kabler, Madison; James T Murphy, La Crosse; C Malcolm Scott, Jr, Superior.

Finances: MDs Vernon M Griffin, Mauston, chairman; William E Martens, Wauwatosa; George V Murphy, South Milwaukee; Paul A Jacobs, Milwaukee.

Credentials Committee: MDs George F Flynn, Milwaukee, chairman; Sandra L Osborn, Madison; Lloyd P Maasch, Weyauwega.

ALBERT J MOTZEL, JR, MD
Speaker

• 1979 BUDGET. We appreciate the effort the Finance Committee of the Council and staff put forth in compiling this very comprehensive document and encourage its use by delegates in reporting to their constituents. This obviously is a lean budget since the 1979 proposed level of expenditures is only 1.3% over 1978 expenses. As indicated, it proposes to add $32,300 to the Society's reserves. In so doing, they will be increased from 2.1 months of normal operating expense to 2.4. A target of not less than three months has been established as a much more realistic level and we should continue to strive for that in the future. The committee recommends adoption of the 1979 budget as presented.

¶Action: ADOPTED

• 1980 DUES. We discussed indepth the dues level not only now but in the future. We are well aware of the absolute necessity for fiscal stability within the Society and in order to carry out that responsibility we see no alternative but to increase dues for 1980. The CPI rose 9% during 1978 and is projected to be about the same in 1979. This obviously has a direct bearing on the Society's budget. Consistent with 1975 action of the House, which established policy that dues be adjusted to reflect effects of inflation, we concur with the Council's recommendation to increase regular member dues by $25, which is a 7.8% increase. The committee recommends that 1980 regular member dues be established at $345 and that future years' dues continue to be adjusted using the Consumer Price Index as a base for such adjustments. ¶Action: ADOPTED

AMA Wisconsin Delegation Honors Howard Brower

Howard Brower (above), former SMS staff member, was presented an honorary award during the State Medical Society's Annual Meeting, May 10-12, in Milwaukee. Eighteen past and present delegates to the AMA presented Mr Brower with a pendulum wall clock in recognition of his "years of dedicated service to AMA delegates." Making the presentation was Henry Twelmeyer, MD, Wauwatosa, who heads the SMS Delegation to the AMA.

HOUGHTON MEDICAL STUDENT AWARD: Douglas M Jackson and Ann Bartos Merkow

Douglas M Jackson, Ann Bartos Merkow, and Robert Cooney, MD, president of the CES Foundation, who made the presentations

Douglas M Jackson, a senior at the Medical College of Wisconsin, and Ann Bartos Merkow, a senior at the University of Wisconsin Medical School, received the Houghton Award of the Society's Charitable, Educational and Scientific Foundation during the Saturday morning session of the House of Delegates in Milwaukee.

Each year the Houghton Award is presented to one or more senior medical students from Wisconsin's two medical schools "who through scholastic excellence, extracurricular achievement and interest in medical organization, shows high promise of becoming a complete physician."

The Houghton Award was established in 1968 by the late John H Houghton, MD, a Wisconsin Dells general practitioner who wanted to emphasize for future doctors the ideals used by the practicing physician. Later, John's brother, William J Houghton, a Milwaukee surgeon, added to the fund.

A native of Madison, Mr Jackson attended Madison West High School and received his Bachelor of Arts degree with honors from the University of Wisconsin—Madison. He spent time this past summer at the Holistic Health Center in Lexington, Kentucky exploring the areas of family practice and holistic health care, and was instrumental in forming a local chapter of the American Medical Student Association on the MCOW campus.

Ms Merkow, a native of Waukesha, received her undergraduate degree from the University of Wisconsin—Milwaukee in nursing. She is a member of Alpha Omega Alpha and has served as a student representative of the Educational Policy Council at the UW Medical School. She has chaired a number of committees in the Medical Student Association and has served as a student member of the Medical School Admissions Committee.

Both Mr Jackson and Ms Merkow received a plaque and a cash award of $100.

● REPORT O—*Wisconsin Medical Journal* EDITORIAL BOARD. We wish to compliment the Editorial Board and staff of the WMJ for their excellent and diligent work. However, we recognize the fiscal impact this activity has on the overall budget and recommend the Council continue to monitor this activity in view of the fact that other lines of communication to members have been established. In addition, we recommend the Council consider and explore the possibility of joining with neighboring states in a combined publication. ¶Action: ADOPTED

● RESOLUTION 10—*Medical Student Loan Repayment.* In hearing testimony by the Resident Physicians Section representatives, it became obvious that the intent of the resolution was not as originally submitted. As a result, we offer the following substitute:

WHEREAS, Many medical students graduate with a significant amount of indebtedness and are on a limited budget during their postgraduate training; and

WHEREAS, Medical student education loans are the responsibility of the individual physician and repayment should be made as soon as possible; therefore be it

RESOLVED, That the State Medical Society of Wisconsin approve in principle the beginning of student loan repayments by the individual physician upon completion of postgraduate training and that this be communicated to appropriate bodies.

¶Action: SUBSTITUTE ADOPTED

● RESOLUTION 11—*Physician Dues Reduction.* There are several existing membership classifications, developed over a period of years, which the committee feels are sufficient to provide adequate dues relief to members unable to pay full dues, and we recommend this resolution be rejected.

¶Action: RESOLUTION REJECTED

● INFORMATIONAL REPORT OF SMS SERVICES, INC. We take note that this new subsidiary of the State Medical Society was organized in 1978 and recommend the report be received. ¶Action: RECEIVED ■

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audit of the State Medical Society of Wisconsin (General Fund) prepared by Bailey, Calmes & Co, certified public accountants.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund
STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1978

	State Medical Society	Wisconsin Medical Journal
INCOME		
Members Dues	$1,162,814.75	$ 20,020.00
Income From Funds Invested	49,151.79	
Annual Meeting Income	30,326.00	
AMA Grant for Study of Health Care in Correctional Institutions	16,323.00	
Revenue From Mailing Labels and Other Items	11,868.99	
Gain on Sale of Fixed Assets	1,659.33	
Advertising Income		72,112.72
Subscription and Supplemental Income		2,336.63
Reprint Income		1,645.96
AMA Collection Fees	7,521.92	
Administrative Fees—Dane County Medical Society	5,000.00	
TOTAL INCOME	$1,284,665.78	$ 96,115.31
EXPENSES		
Payroll	$ 597,353.05	$ 30,191.58
Payroll Related Costs	126,741.03	9,663.59
President and President Elect Travel	3,240.44	
AMA Annual Clinic and Special Meetings	9,600.00	
Conference Expense	39,897.85	75.68
Association Dues	2,481.66	
Travel Expense	107,585.22	587.26
Telephone Expense $72,163.52; Less Telephone Costs Recovered 22,690.49	49,473.03	2,133.91
Printing and Forms	62,733.72	253.44
Postage	29,360.05	4,060.93
Insurance—General	10,544.45	578.54
Grants and Appropriations	22,430.00	
Cafeteria Expense $17,270.13; Less Cafeteria Costs Recovered 14,443.84	2,826.29	202.05
Speakers Expense	7,081.53	
Office Services	93,863.02	5,208.40
Outside Services	58,895.32	72.60
Miscellaneous Expense	6,017.37	
Accounting Services	8,535.46	1,054.03
Legal Counsel	28,517.50	372.00
Depreciation	4,208.22	253.91
Office Rent	74,703.90	4,011.35
Resource Material	3,713.13	281.97
Journal Printing—Net of Reimbursed Costs		46,246.04
Advertising Expense		9,091.39
Uncollectible Items		741.67
Other Publication Expenses		3,611.81
Total	$1,349,802.24	$118,692.15
Less Portion of Above Expenses Recovered by Services Furnished to Others	35,785.69	
NET EXPENSES	$1,314,016.55	$118,692.15
Excess Income Over Expense Before SMS Realty Corporation	($ 29,350.77)	($22,576.84)
SMS Realty Corporation Distribution of Income	5,826.35	
Income of SMS Services, Inc	420.49	
Net Income Over Expense	($ 23,103.93)	($22,576.84)

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund
BALANCE SHEET
December 31, 1978

ASSETS		
Current Assets		
Cash		$ 201,987.07
Employee Travel Advances		3,600.00
Accounts Receivable—General		108,695.99
Due From SMS Realty Corporation		18,278.43
Due From Employees Pension Plan		1,366.92
Due From Wisconsin Health Care Review, Inc.		9,919.15
Due From SMS Services, Inc.		18,438.35
Due From Wisconsin Medical Journal Advertisers		11,622.14
Due From Other Organizations for Accrued Vacation Pay		6,011.78
Commercial Paper		530,300.60
US Treasury Bills		138,502.67
Certificates of Deposit		300,000.00
Common Stock—at Cost (Market Value $12,638.25)		8,361.52
Accrued Investment Income Receivable		3,592.87
Prepaid Expenses		29,115.92
Printing and Forms Inventory		16,269.76
Total Current Assets		$1,406,063.17
Fixed Assets		
Furniture and Equipment	$ 113,701.95	
Less: Accumulated Depreciation	62,357.91	
Total Fixed Assets		51,344.04
Other Assets		
Investment in SMS Services, Inc.		50,420.49
TOTAL ASSETS		$1,507,827.70
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable		$ 72,461.50
Due Charitable, Educational and Scientific Foundation, Inc		2,439.32
Dues Held for the Section on Ophthalmology		8,809.96
Dues Held for the Milwaukee Auxiliary		1,900.00
Accrued Payroll Taxes and Other Payroll Deductions		24,497.07
Unapplied Membership Dues		2,005.00
Accrued Vacation Pay		48,026.37
Retirement Plan Contribution Payable		12,423.41
Advertising Commissions Payable		1,641.27
Dues Payable to the American Medical Association, County Medical Societies and Related Organizations		4,172.00
Accrued Property Taxes		1,773.79
Other Liabilities		403.05
Deferred Income:		
Prepaid Membership Dues	$1,089,474.00	
Prepaid Exhibit Rental	11,925.00	
Total Deferred Income		1,101,399.00
Total Current Liabilities		$1,281,951.74
NET WORTH		
Capital, January 1, 1978	$ 271,556.73	
Less Expense Over Income—1978 Operations:		
General Fund	$23,103.93	
Wisconsin Medical Journal	22,576.84	45,680.77
Total Capital, December 31, 1978		225,875.96
TOTAL LIABILITIES AND CAPITAL		$1,507,827.70

EDITOR'S NOTE: Notes accompanying the foregoing statements in the original Certified Audit are not included here because of space limitations. ■

Organizational SMS

Nominations sought for Society Offices

On Sunday, September 30, at 10:00 am the House of Delegates Nominations Committee will meet at SMS Offices in Madison. The following positions will be open for nominations to be made to the House of Delegates at the 1980 Annual Meeting, March 27-29: President-elect for 1980-81; Vice-speaker of the House of Delegates for 1980-81 to succeed Duane W Taebel, MD, LaCrosse; AMA delegates for calendar years 1981 and 1982 to succeed John K Scott, MD, Madison; Patricia J Stuff, MD, Bonduel; and De Lore Williams, MD, West Allis; AMA alternate delegates for calendar years 1981 and 1982 to succeed Richard W Edwards, MD, Richland Center; Cornelius A Natoli, MD, LaCrosse; and John D Riesch, MD, Menomonee Falls.

All members and county medical societies are urged to take part in the nomination process. Nominations and curriculum vitae should be mailed to the committee at the State Medical Society in advance of the September meeting. All candidates, with a member of the Society to nominate them, should be present at the September 30 meeting to present their views and answer any questions.

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

Durkin urges MDs to join Medicaid program

The State will intervene unless those Wisconsin physicians who still are boycotting the Medicaid program join it soon and provide needed service to the poor, Division of Health Administrator Robert Durkin told the State Medical Society's House of Delegates at its opening session May 10. "The department has an obligation to see that medical care is available to its eligible clients. If the voluntary healthcare system abdicates its responsibility to provide care, then the state government will be forced to fill the gaps," Durkin said. He urged the Medical Society to persuade "this handful of doctors that their strike against Medicaid is but a strike against the poor and helpless and betrays the best tradition of medicine." If physicians do not cooperate in joining the program in areas that need Medicaid providers, the State would provide service for Medicaid patients by bringing in state-employed physicians from the National Health Service Corps.

SMS Fall Tour to Italy

The State Medical Society is offering a guided tour to Italy, September 20-28, as a membership benefit through the SMS Services, Inc. Cost of the tour is $899 per person double occupancy including the following features: round trip jet air transportation Milwaukee/Rome with food and beverages. First class accommodations with private bath including tax. Continental breakfast daily with lunch and dinner in Florence. Tour price also includes sightsceing, water transportation, and entrance fees for entire itinerary as well as all transfers, tips, and taxes. All motorcoach transportation will be air-conditioned and there will be an English-speaking courier accompanying the group throughout. The duty free customs allowance has been raised to $300 per person. *The American dollar travels better in Italy than most of Europe.* To assure space confirmation and for further information, members should contact SMS Services, Inc, Attn: Peter Wood, PO Box 1109, Madison, Wis 53701; or phone toll-free 1-800-362-9080, outside the Madison area.

Doctors Michael Mehr and Richard Ulmer of Marshfield escorting the new president-elect, Dr Russell F Lewis (right) of Marshfield to the podium for introduction to the House of Delegates at the 1979 Annual Meeting, May 10-12, in Milwaukee. A summary of the House actions appears elsewhere in this issue.

New President-elect

Russell F Lewis, MD, Marshfield

Graduate of University of Wisconsin Medical School, Madison. Served in United States Army 1942-1946. On the medical staff of Marshfield Clinic from 1946 to present. Residency in OB-GYN at University of Wisconsin Hospitals, Madison, 1951-1953. President of Marshfield Clinic 1960-1962 and 1966-1968. Served on Board of Directors of Marshfield Clinic Foundation for Education and Research, 1958-1971 and on Board of Directors University of Wisconsin Stevens Point Foundation, 1967-1976. Fellow, American College of Surgeons in 1959. Member of American College of Obstetricians-Gynecologists, 1954. Member of Marshfield Clinic Executive Committee, 1953-1968. Member and former chief of Obstetrics Department, St Joseph's Hospital, Marshfield. Member, Wood County Medical Society. Member of advisory committee Wisconsin Regional Medical Program 1967-1973 and vice-chairman, 1969-1973. President of Wisconsin Society of Obstetrics and Gynecology in 1954 and member since 1947. Medical director of Marshfield Clinic 1969-1977. Councilor from fourth district to State Medical Society, 1971-1980. Member of North Central Area Health Planning Committee and served as chairman in 1976-1977. Member, American Academy of Medical Directors, VTAE State Paramedical Advisory Committee. Board member and vice-chairman Board of Control, Wisconsin Professional Review Organization (WisPRO). Medical Director of Greater Marshfield Community Health Plan, 1971 to present.

Dr Lewis

New councilors

DISTRICT 2

Cyril Hetsko, MD, Madison

Born May 25, 1942 in Montclair, New Jersey. Graduated from University of Rochester School of Medicine, Rochester, New York, 1968. Served in United States Army, 1972-1975, at US Army Medical Research Institute of Infectious Diseases, Frederick, Maryland. Wisconsin license, 1969. Certified by American Board of Internal Medicine, 1974. Member of American Thoracic Society. Member Dean Clinic in Madison since 1975. On medical staff of St Marys Hospital Medical Center. Elected to Council, May 1979, for a three-year term.

J D Kabler, MD, Madison

Born Dec 29, 1926 in Wichita, Kansas. Graduated from University of Kansas Medical School, 1950. Interned at University of Wisconsin Hospitals, Madison, 1951-1952. Wisconsin license, 1951. Served in the United States Navy, 1952-1954. Certified by American Board of Internal Medicine, 1958. Appointed chief surgeon of Wisconsin National Guard, 1967. Subspecialty: Psychosomatic Medicine. Member and cochairman, Joint Practice Committee, in existence for five years. Member, SMS Commission on Governmental Affairs, 1976-1979. Professor of Medicine, University of Wisconsin-Madison. Director, University Health Service. Elected to Council, May 1979, for three-year term.

Dr Hetsko

Dr Kabler

Dr Kempthorne

Gerald C Kempthorne, MD, Spring Green

Born Sept 18, 1930 in Platteville, Wisconsin. Graduated from University of Wisconsin-Madison with BS degree; Kansas State University, Manhattan, Kansas, MS degree; and University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, Maryland, MD degree, 1961. Served in United States Navy, 1951-1954. Rotating internship at Cook County Hospital, Chicago, Illinois, 1961-1962. Wisconsin license, 1962. Began medical practice in Spring Green in 1962. On medical staffs of Sauk Prairie Memorial Hospital, Prairie du Sac, and St Marys Hospital Medical Center, Madison. Served as president of Sauk Prairie Memorial Hospital medical staff. Served as president of Sauk County Medical Society, 1966. Member of American Academy of Family Physicians and American Academy of Psychosomatic Medicine. Served on Board of Directors, Sauk County Mental Health Association. Health Officer of Spring Green. Fellow and diplomate of American Academy of Family Physicians, 1975. Served as member and chairman of SMS Committee on Grievances, starting in 1972, then changed to Commission on Public and Professional Affairs, 1975; changed to Commission on Mediation and Professional Ethics, 1977; and in 1979 merged with Commission on Peer Review with a new name of Commission on Mediation and Peer Review. Received interim appointment as councilor in October 1978 replacing Richard W Edwards, MD of Richland Center who was elected AMA alternate delegate. Elected to Council, May 1979, for three-year term.

DISTRICT 3

Pauline Jackson, MD, LaCrosse

Born Sept 16, 1926 in Santa Barbara, California. Graduated from Stanford University with BA degree in Basic Medical Science. Graduated from Stanford University School of Medicine, 1961. Interned at Charles T Miller Hospital, St Paul,

Minnesota. Residency served at Cleveland Psychiatric Institute, Ohio. Wisconsin license, 1972. Practiced at Napa State Hospital, California, three years, then Fallsview Mental Health Center, Ohio, four years. Practicing psychiatrist at Gundersen Clinic Ltd in LaCrosse. Board certified in Psychiatry and Neurology. Member of American Psychiatric Association. Elected to Council, May 1979, to fill unexpired term (1977-1980) of Cornelius A Natoli, MD, LaCrosse, who was elected AMA alternate delegate.

CONTRIBUTIONS CES FOUNDATION MAY 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1979.

Unrestricted

SMS Members; Waukesha County Medical Society Auxiliary; Brown County Medical Society Auxiliary; Fond du Lac County Medical Society Auxiliary; Eau Claire-Dunn-Pepin County Medical Society Auxiliary—*Voluntary Contributions*

Restricted

Robert B Murphy; Leland Pomainville, MD; County of Crawford—*Museum of Medical Progress*

RH Siedenburg, MD; Professional Arts Building Co-Manitowoc; Doctors Park Associates of Beloit; St Croix Falls Clinic; Community Medical Group-Mondovi; Francis Gilbert, MD; Waukehsa Family Practice Center; CD Brummitt, MD; Cross Plains Clinic; Doctors Clinic of Wisconsin Rapids; Red Cedar Clinic-Menomonie; East End Clinic-Superior — *Medical Student Summer Externship Program*

Membership Dues; Elizabeth J Jauquet — *Aesculapian Society*

Memorials

Dr-Mrs Charles J Picard; Dr-Mrs William D James—*Joseph C Griffith, MD*

Robert B Murphy—*C O Vingom, MD; Elwood Mason, MD*

Mr-Mrs Earl R Thayer; John M Bell, MD; EJ Nordby, MD—*Anthony R Curreri, MD*

State Medical Society—*SH Wolter, MD; Chester W Long, MD*

Dr-Mrs Henry C Rahr—*Kay Sehring*

Parks Reinhardt; The HB Maroneys; Mr-Mrs ER Thayer; Mavis & Reese Minor; Dr-Mrs EJ Nordby; Milton Finn, MD—*Ralph Anderson*

Dee Miller—*Ralph Anderson (Student Loan Fund)*

EJ Nordby, MD; Gerald Kempthorne, MD—*John B Wear, MD*

Dr-Mrs EJ Nordby—*Gunnar Gundersen, MD*

Marion P Crownhart—*Anthony Curreri, MD; Ralph Anderson (Crownhart Memorial Fund)*

Dr-Mrs Robert T Schmidt Jr; Dr-Mrs Robert T Schmidt—*Mrs Kay Sehring (Brown County Loan Fund)*

Dr-Mrs Robert T Schmidt—*Mr Richard Bourguinon; Mrs Minolia Bercean; Mrs Loretta Mackin (Brown County Loan Fund)*

Dr-Mrs Donald Rowe—*CC Gascoigne, MD (Nurse & Allied Medical Careers-Student Loan Fund of the Woman's Auxiliary to Sheboygan County Medical Society)*

DISTRICT 4

Jung K Park, MD, Wisconsin Rapids

Born Oct 5, 1937 in Korea. Graduated with BA degree from Park College, Parkville, Missouri. Graduated with MD degree from University of Missouri School of Medicine, Columbia, Missouri, 1965. Served internship and residency at Georgetown University Medical Center, Washington, DC in Pathology. Served four-year residency in Pathology and Hematopathology at University of Chicago. Wisconsin license, 1979. Certified by American Board of Anatomic and Clinical Pathology. Currently pathologist at Riverview Hospital and St Michael's Hospital in Wisconsin Rapids. Elected to Council, May 1979, to fill unexpired term (1977-1980) of Russell F Lewis, MD, Marshfield, who was elected president-elect.

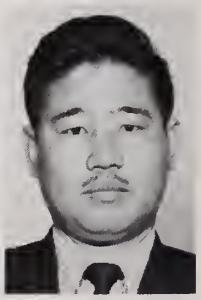
DISTRICT 6

Irvin L Schroeder, MD, Sheboygan

Born Sept 24, 1918 in Clintonville, Wisconsin. Graduated from Marquette University School of Medicine, Milwaukee, 1943. Interned, Milwaukee County General Hospital, 1943-1944. Residency, Milwaukee County General Hospital, 1944-1945 and 1947-1950. Served in United States Army, 1945-1947 (Korea). Certified by American Board of Surgery. Practiced in Sheboygan, 1951-1976. Associated with Plymouth Hospital as full-time general surgeon, 1976 to present. Member, American College of Surgeons and Wisconsin Surgical Society. Elected to Council, May 1979, for three-year term.

Dr Jackson

Dr Schroeder



Dr Park

SMS annuity unit value: $2.57

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.57 as of May 31, 1979. ■

Obituaries

◈County, State, AMA Members

Thomas Furlon Jr, MD, Bryn Mawr, PA, died Feb 18, 1979 in Bryn Mawr, PA. Doctor Furlon was retired and at one time served as chief of the Department of Ear, Nose and Throat at Bryn Mawr Hospital. Born in Milwaukee, he is survived by his widow, Frances, two daughters, Mrs Barbara Jane Clark, Claremont, CA, and Mrs Nancy Salisbury, North Stanford, CT; and two sons, Thomas F and Edward J of Pennsylvania.

◈ **Julius Heil, MD,** 74, former Milwaukee physician, died Mar 14, 1979 in Poway, Calif. Born May 22, 1904, Doctor Heil graduated from Marquette University School of Medicine in 1930. He served in the United States Army Medical Corps from 1942-1946. He was the physician for the Heil Company, Milwaukee, and also was in private practice until his retirement in 1968. Surviving are his widow, Helen; and two daughters, Julaine Landreth and Judy Nash, all of California.

◈ **Serenus Henry Wolter, MD,** 79, Milwaukee, died Mar 23, 1979 in Milwaukee. Born Feb 23, 1900 in Clayton County, Iowa, Doctor Wolter graduated from Marquette University School of Medicine in 1925. He had practiced medicine in Milwaukee from 1928 until the time of his death. He was on the medical staffs of St Mary's, Milwaukee Lutheran and Milwaukee County General hospitals. Doctor Wolter also was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are his widow, Rosemary; four sons, Thomas, Decatur, Ala; James, Libertyville, Ill; John, Chippewa Falls, and Daniel of Whitefish Bay; and a daughter, Maryann Paulus of Milwaukee.

Henry L Vogl, MD, 72, former chief medical officer at Veterans Administration Hospital, Wood, died Apr 7, 1979 in Milwaukee. Born Apr 13, 1906 in Milwaukee, Doctor Vogl graduated from Marquette University School of Medicine in 1931. He served at VA hospitals in Asheville, NC, Johnson City, Tenn, and Marion, Ill. He was chief medical officer in 1951 at the Veterans Administration Hospital in Wood, and was transferred to the VA Hospital at St Paul, Minn, until he retired in 1969. Surviving is his widow, Lydia.

◈ **Chester William Long, MD,** 76, Milwaukee, died Apr 8, 1979 in Milwaukee. Born Nov 9, 1902 in Stanley, Doctor Long graduated from the University of Wisconsin Medical School, Madison, in 1927. He had practiced in Milwaukee since 1929 and for the last five years had been semi-retired. He served on the medical staffs of Columbia, St Mary's and Milwaukee Lutheran hospitals. Surviving are his widow, Kathryn; a son, David, and a daughter, Constance both at home.

◈ **Cyril Robert Marlewski, MD,** 75, Pompano Beach, FL, died Apr 21, 1979 in Pompano Beach. Born Nov 9, 1904 in Milwaukee, Doctor Marlewski graduated from Marquette University School of Medicine in 1932. He served in the United States Army from 1942 to 1946 and retired from medical practice in 1964. Surviving is his widow Cornelia.

◈ **John Collins Griffith, MD,** 80, Oconomowoc, died April 22, 1979 in Oconomowoc. Born Nov 10, 1898 in the town of Summit, Doctor Griffith graduated from Marquette University School of Medicine in 1923. He had practiced in Milwaukee since 1923 and at the time of his death, he was still practicing two days a week. He served as president of the Medical Society of Milwaukee County in 1948, and was president of the State Medical Society of Wisconsin from 1952-1953. He was an alternate delegate to the American Medical Association from 1951 - 1955 and a delegate from 1956 - 1959. Doctor Griffith served as chief of the medical staff at Misericordia Hospital and also as chief of the Department of Surgery. Surviving are his widow, Mildred; four daughters, Mrs John (Marianna) Haugh and Mrs John (Terry) Bartzen both of Shorewood; Mrs Kenneth (Susan) Seidenstricker, Denver, Colo; Mrs Alice Kudlata of Fox Point; one son, William, Menasha; 32 grandchildren and three great grandchildren.

Santo S Torcivia, MD, 73, Milwaukee, died Apr 29, 1979 in Milwaukee. Born Jan 1, 1906 in Italy, Doctor Torcivia graduated from Marquette University School of Medicine in 1931. Doctor Torcivia served on the medical staff of the Veterans Administration Hospital in Wood. Surviving are his widow, Anno; three daughters, Mary Catherine Luedtke; Suzanne Haskell, and Anno Goshgarian; and one son, James.

◈ **Anthony R Curreri, MD,** 69, Madison, a nationally known University of Wisconsin cancer and surgery expert, died May 3, 1979 in Madison. Born Sept 18, 1909 in Brooklyn, New York, Doctor Curreri graduated from the University of Wisconsin Medical School, Madison, in 1933. After residency training he was named an instructor in the UW Medical School's surgery department in 1939, and advanced to full professor in 1954. When the UW Cancer Research Hospital was opened in 1948, Doctor Curreri was named its first director. When it evolved into the medical school's Division of Clinical Oncology in 1963, he continued as director.

In 1968 Doctor Curreri was appointed chairman of the Surgery Department, and in 1972 he was named associate vice chancellor for health sciences. In January 1974 he left Madison to become the first president of the Uniformed Services University of the Health Sciences, a medical school for military personnel, in Washington, DC. He returned to the UW in 1976 to resume his teaching duties.

At the time of his death Doctor Curreri was the Evan P Helfaer distinguished professor of surgery at the UW Medical School and also was chief of

staff for education at the Veterans Administration Hospital.

In addition to his pioneering work in cancer research, Doctor Curreri held important military posts. In 1952 he spent time in Korea studying the use of dextran, a synthetic substitute for plasma in preventing shock in wounded troops. He also was a consultant to the Surgeon General during the Vietnam conflict. For his years of government service, he received the Defense Department's highest civilian medal in 1977—the Distinguished Public Service Award.

In 1972 Doctor Curreri was appointed to a newly-created position as assistant vice chancellor for health sciences at the University of Wisconsin-Madison. The position involved wide-ranging responsibilities for coordination of development of the new Center for Health Sciences. These included program review and development and liaison with state and federal agencies involved in the new construction project.

His contributions to cancer research and teaching have included service on numerous national medical advisory councils.

Doctor Curreri was a staunch supporter of organized medicine and encouraged his colleagues at the university to join the medical societies. As a member of the State Medical Society's Committee on Cancer and the Council on Scientific Work (now the Commission on Continuing Medical Education), Doctor Curreri helped shape Society policies and programs.

A Madison *Capital Times* editorial commented: "Dr Curreri was a highly acclaimed surgeon, whose dedication to his profession prolonged the lives of thousands of persons. His patients came to the University of Wisconsin Hospitals from far and near to seek his aid and his counsel and to enlist his skills in the battle against disease, most frequently dreaded cancer. Those sojourners found a proficient and sympathetic physician, and a warm-hearted person who put his patients at ease and gave them renewed courage in their battle against illness. Tony Curreri didn't win all of those battles by any means, but he won enough of them to give him a national reputation and many honors. Curreri was not only highly respected by his academic colleagues, he was one of those individuals who could bridge with ease the gap between town and gown. His undergraduate exploits as a member of the UW boxing team and the Badger baseball nine made him a popular off-campus figure. The university made ample use of the popularity. Dr Curreri was one of its best known liaisons with the Legislature, particularly at budget time. Dr Curreri has been in Madison so long that it is hard to remember that he came here as a non-resident student back in 1925 from New York City. He was awarded an MD degree here in 1933 and his distinguished career since exemplified the enrichment Wisconsin has gained from out-of-staters. Curreri loved this community and Wisconsin."

Surviving are his widow, the former Dorothy Huebsch; a son, Dr P William Curreri, professor of surgery at Cornell University; and two daughters, Cynthia Brady of Seattle, Wash, and Joanne Bonni Falcon of Brookfield.

Editorial reprinted from
THE CAPITAL TIMES, May 7, 1979

Anthony R Curreri, MD: 1909-1979

It would be fitting for the University of Wisconsin to name its new $100-million medical center for Dr Anthony Curreri. It would not have been completed but for Curreri. He was the university's best lobbyist in Washington and in the State Capitol. The name Tony Curreri had a magic on Capitol Hill in Washington as well as state government.

Curreri was a sympathetic physician and skilled surgeon who battled cancer in his patients with the same vigor he had used as a champion boxer as an undergraduate at the University of Wisconsin. Tony was the personal physician of many Wisconsin governors, including Lee Dreyfus, Warren Knowles and Pat Lucey. He administered to scores of legislators past and present. It would be only a slight overstatement to call him the physician to the Legislature . . . . If Tony was at the forefront of medicine, he learned his skill as a listener in a less hurried era of medicine. The whole Tony Curreri made him an important figure in state government, especially when the UW Medical Center project was in financial trouble. . . .

Curreri was a member of the Piscatorial and Inside Straight Society, the social group of powerful Wisconsin figures which grew up in the 1950s. But if this recitation makes Curreri seem like a society mover and a man interested only in the powerful, it is unfair. Tony cared about little people and their problems. Often his presence was only in the background . . . Tony offered his medical skills to those with little ability to influence the comings and goings of medicine and government. . . .

The powerful will remember Curreri as a physician and friend. The university will remember Curreri for helping construct the University Medical Center. Many families will remember him as a sympathetic healer who would travel hundreds of miles out of his way.

Naming the new hospitals the Anthony Curreri Medical Center would be a symbol of what the University of Wisconsin hopes medicine will achieve—the most skilled care available, accompanied by humaneness, care and understanding.

◈ **Albert S Daniells, MD,** 51, Tomah, died Apr 26, 1979 in Tomah. Born January 17, 1928 in Chakardarpore, India, Doctor Daniells graduated from Medical College in Nagpur, India in 1955. Prior to joining the Landmann Clinic in Tomah in 1973, Doctor Daniells had been in private practice in Arcadia and also was a member of the Krohn Clinic in Black River Falls. At the time of his death, he was chief-of-staff of Tomah Memorial Hospital. Surviving are his widow, Ruth; three sons, Richard, Douglas and David; and two daughters, Barbara and Patricia, all at home.

◈ **Joseph A Russell, MD,** 75, Random Lake physician for 43 years, died Apr 27, 1979. Born Oct 5, 1903 in Hartford, Doctor Russell graduated from Marquette University School of Medicine in 1929. A general practitioner who has served the Random Lake area since 1936, Doctor Russell was a past president of the Sheboygan County Medical Society and was on the medical staffs of St Nicholas and Sheboygan Memorial hospitals. Doctor Russell had been semi-retired since 1977. Surviving are his widow, Katherine, and one son, Dr. Thomas J Russell of Milwaukee.

◈ **William J Waldschmidt, MD,** 100, Fond du Lac, believed to have been the oldest living member of the State Medical Society of Wisconsin, died May 2, 1979 in Fond du Lac. Born Nov 4, 1878 in Fond du Lac, Doctor Waldschmidt graduated from Northwestern University School of Medicine, Chicago, in 1905. Doctor Waldschmidt was a partner in Wiley-Smith Clinic, Fond du Lac, until his retirement. He was a member of the "50 Year Club" of the State Medical Society and was granted a life membership in 1963. He is survived by three sisters, Mrs. Harriet B Breitengross, Milwaukee; Mrs Kathryn M Heller, Fond du Lac; and Mrs Meta C Johnson of Sun City, Ariz.

◈ **Clarence C Gascoigne, MD,** 74, Brandenton, Fla, died May 5, 1979 in Adrian, Mich. Born Sept 20, 1904 in Kenosha County, Doctor Gascoigne graduated from Marquette University School of Medicine in 1930. He became associated with the Kohler Company in 1936 and retired as its medical director in 1970. Surviving are his widow, Florence; and two sons, Dr Richard of Adrian, Mich, and Dr James of Tuscaloosa, Ala.

◈ **William Lyman Caldwell, MD,** 49, Madison, died May 21, 1979 north of Fort Francis, Ontario, Canada. Born Nov 12, 1929 in Honolulu, Hawaii, Doctor Caldwell graduated from Stanford University Medical School in 1955. He served in the United States Army Medical Corps and from 1959-1963 he was chief of the Radiology Service at Rodriguez United States Army Hospital in San Juan, Puerto Rico. Doctor Caldwell served as a special fellow of the United States Public Health Service at the Royal Marsden Hospital in Sutton, Surrey, England, and the Institute of Cancer Research in London, England. He came to University Hospitals, Madison, in 1971 as the director of the Radiation Oncology Division. At the time of his death, he was the associate director of the Wisconsin Clinical Cancer Center, director of the Radiation Oncology Division, and professor of Human Oncology and Radiology. Surviving are his widow and six children. (Further details appear with the Cancer Column in this issue)

◈ **William Joseph Tucker, MD,** 87, Ashland physician since 1921, died May 29, 1979 in Ashland. Born July 20, 1891 in St Louis, Mo, Doctor Tucker graduated from the University of St Louis Medical School in 1914. After internship he was associated with the Mayo Clinic, Rochester, Minn, before moving to Ashland in 1921. Doctor Tucker was one of the founding members of the American Board of Abdominal Surgery. Surviving are three sons, Thomas, Ashland; William, St. Louis, Mo; and Edmund, LaCrescent, Minn; and two daughters.

Fin Gerhard Anderson, MD, 85, the last surviving founder of the Midelfort Clinic, Eau Claire, died June 7, 1979 in Eau Claire. Born Nov 10, 1893 in Eau Claire, Doctor Anderson graduated from Northwestern University Medical School in 1920. He was a surgeon at the Midelfort Clinic for 50 years and also served as chief-of-staff at Luther Hospital and was on the board of directors. ■

SMS publications available for physicians' office

Several publications aimed at the general public are available to SMS members at no charge. These include:

- *To All My Patients, Partners in Good Health*—a brochure discussing the physician/patient relationship and each other's rights and responsibilities. Available in both reception area and statement stuffer sizes.
- *I Want to Know What You Think*—a patient questionnaire for use in a physician's office.
- *Alcohol and Your Unborn Baby*—a brochure available in both English and Spanish versions which warns women about the fetal alcohol syndrome (FAS).
- *Rubella*—a brochure urging women to become immunized against German measles or rubella.
- *To Your Good Health*—a brochure explaining why health care costs have risen and what patients can do to contain these costs.

Physicians can order these publications by contacting the SMS Communications Dept at PO Box 1109, Madison, Wis 53701.

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of May 25, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/subspecialty)

County Medical Society

BARRON-WASHBURN-BURNETT

Branham, Roger V, 1024 N Main St, Rice Lake 54868 (1945, Regular, Orthopedic Surgery)
Nymo, Mark T, 1020 Lake St, Rice Lake 54868 (1949, Regular, Family Physician, Certified)
Thalacker, Howard A, 220 Douglas St, Chetek 54728 (1943, Regular, Family Physician, Certified)

BROWN

Bauer, Cynthia A W, 422 E Lecapitaine Cir, Green Bay 54302 (1948, Regular, Emergency Medicine)

DANE

Adib, Khosro, 234 Randolph Dr., Madison 53717 (1945, Resident, Cardiovascular Surgery/General Surgery)
Smith, Jane C, 4113 Major Ave, Madison 53716 (1948, Resident, Child Psychiatry/Psychiatry)

DODGE

Smith, John Alan, Rte 1, Hwy 28, Horicon 53032 (1913, Regular, Family Physician)

JEFFERSON

Heffelfinger, John C, 700 Hoffmann Dr, Watertown 53094 (1924, Regular, Pediatrics, Certified)

KENOSHA

Clubb, Meredith C, 6215 10th Ave, Kenosha 53140 (1947, Regular, Urology)

MANITOWOC

Driggers, Steven D, 600 York St, Manitowoc 54220 (1949, Regular, Family Physician)
Goodwin, Max H, 2219 Garfield St, Two Rivers 54241 (1948, Regular, Family Physician)
Kay, Howard H, 601 Reed Ave, Manitowoc 54220 (1949, Regular, Pediatrics)
Lockey, James E, 601 Reed Ave, Manitowoc 54220 (1946, Regular, Internal Medicine/Pulmonary Diseases, Certified-IM)
Schlernitzauer, D A, 1119 Marshall St, Manitowoc 54220 (1942, Regular, Ophthalmology)
Schmidt, Gary A, 600 York St, Manitowoc 54220 (1949, Regular, Family Physician)
Trader, Joseph E, 501 N 10th St, Manitowoc 54220 (1946, Regular, Orthopedic Surgery, Certified)

OCONTO

Glazier, Edward H, 855 S Main St, Oconto Falls 54154 (1931, Regular, Emergency Medicine/Obstetrics and Gynecology)
Losh, David P, 907 Main St, Oconto 54153 (1949, Regular, Family Physician)

ONEIDA-VILAS

Furda, Joel L, 1020 Kabel Ave, Rhinelander 54501 (1949, Regular, Internal Medicine)
Janak, Steve W, PO Box 549, Woodruff 54568 (1949, Regular, Family Physician)
Liebl, R Scott, PO Box 549, Woodruff 54568 (1946, Regular, General Surgery/Cardiovascular Surgery)
Pagano, Judith S, Rte 2, Box 1695, Rhinelander 54501 (1944, Regular, Obstetrics and Gynecology, Certified)

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OZAUKEE

Pojunas, Thomas J, 12402 Lake Shore Dr, Mequon 53092 (1947, Regular, Orthopedic Surgery)

RACINE

Stefanowicz, Helena, 1242 S Main St, Racine 53403 (1923, Regular, Anesthesiology)

TREMPEALEAU-JACKSON-BUFFALO

Gilbert, Kenyon R, Rte 1, Box 143, Blair 54616 (1937, Regular, Emergency Medicine/Family Physician)

WAUKESHA

Birkholz, Steven W, 869 Summit Ave, Oconomowoc 53066 (1948, Resident, Orthopedic Surgery)

WOOD

Bowers, Timothy L, 1041 Hill St, Wisconsin Rapids 54494 (1948, Resident, Family Physician)
Swanson, Mark K, 1000 N Oak Ave, Marshfield 54449 (1943, Regular, General Surgery, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

BARRON-WASHBURN-BURNETT

Matson, Kenneth L, Sun City, Ariz, to Rte 1, Box 225, Sarona 54870

DANE

Ansfield, Fred J, Mequon, to PO Box 41, Clam Lake 54517
Waskow, William L, Madison, to Rte 2, Box 110-N, Brooklyn 53521

GRANT

Nuland, Stanley J, Platteville, to 6430 N Sunset Lane, Milwaukee 53217

JEFFERSON

Netzow, Earl J, Johns Island, SC, to Rte 1, Box 51F, Cedar Grove 53013

MANITOWOC

Radl, Cyril J, Scottsdale, Ariz, to 1425 N 9th St, Apt 4, Manitowoc 54220

MILWAUKEE

Garner, Lawrence L, La Jolla, Calif, to PO Box 1608, Milwaukee 53201

WOOD

Vedder, James S, Anna Maria, Fla, to PO Box 664, Marshfield 54449
Carson, Robert G, Green Bay, to 59 Racine St, Menasha 54952

DEATHS

Heil, Julius V, Milwaukee County, Mar 14, 1979
Marlewski, Cyril R, Milwaukee County, Apr 21, 1979
Griffith, Joseph C, Milwaukee County, Apr 22, 1979
Daniells, Albert S, Monroe County, Apr 26, 1979
Russell, Joseph A, Sheboygan County, Apr 27, 1979
Waldschmidt, W J, Fond du Lac County, May 2, 1979
Curreri, Anthony R, Dane County, May 3, 1979
Cascoigne, C C, Sheboygan County, May 5, 1979
Gundersen, Gunnar Sr, LaCrosse County, May 22, 1979 ■

Toll-Free WATS line for members: 1-800-362-9080

As a service to its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference!

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Physicians Alliance

BRIAN JENSEN, Director
Physicians Alliance Division

Governmental Affairs reviews pending legislation

The SMS Governmental Affairs Commission discussed a number of bills currently pending before the Legislature at its June 13 meeting in Madison.

At that meeting the Commission:

- Deferred action on legislation Rep Richard Flintrop (D-Oshkosh) plans to introduce, which would allow adults to execute directives authorizing suspension of extraordinary means of life support when the person is afflicted by an irreversible illness. This "Right to a Natural Death Act" would require the primary physician to retain the directive in the patient's medical records. Failure to comply with the directive would constitute unprofessional conduct unless the patient is transferred to another physician who will comply.
- Referred a bill relating to the licensing of athletic trainers by the Medical Examining Board to the SMS Committee on School Health for its recommendations.
- Reviewed a bill which would require ambulance attendants' (EMTs) course of instruction to include treatment of anaphylactic shock resulting from insect stings. The Commission directed legal counsel to research present law for clarification regarding injections by EMTs.
- Approved a legislative proposal which would require every public and private high school to provide instruction in CPR, including mouth-to-mouth resuscitation and external cardiac compression.
- Unanimously rejected a proposal which would repeal a statutory requirement that municipalities or counties pay the cost of emergency hospital care furnished to indigent persons. Present law requires hospitals to notify the general relief agency within seven days of admission to receive payment. If the legislation is passed, hospital charges, and often physician fees, would be virtually uncollectible for those services.

Surgical Care—Blue Shield's physician reimbursement limit studied

The SMS Physicians Alliance Commission expressed concern at its meeting June 15 over Surgical Care-Blue Cross's current 6.5% limit on increases in physician reimbursement and the company's unilateral determination of what constitutes usual, customary, and reasonable (UCR) charges for physicians' services. The Commission voted to prepare a special mailing for the Society membership on the reimbursement limit advising them how to challenge UCR determinations made by Surgical Care.

It is necessary, the Commission said, that the Society help physicians legally advise their patients that Surgical Care coverage, in some instances, may not cover physician charges for medical services as determined by the physician. In this event, the patient must understand that he or she is responsible for the difference the Commission said.

In other action the PA Commission:

- Appointed a special ad hoc committee to investigate existing state and federal laws concerning the establishment of collective bargaining units for employed physicians.
- Endorsed an intensive membership development campaign for the State Medical Society to be undertaken this fall. Under this plan, Physicians Alliance commissioners, councilors, county medical society officers and other SMS commission members will be called upon to help implement the effort. The campaign will utilize specially prepared promotional materials citing the benefits of SMS membership and will be targeted at 21 counties designated as "priority areas" for membership development purposes.

Medical Liability Committee acts on many bills

A legislative proposal which would render formal patient compensation panel findings inadmissible in court was vigorously opposed June 15 by the SMS Medical Liability Committee. In citing its reasons for opposing Assembly Bill 655, the Committee said the bill would drastically limit the effectiveness of the patient compensation process in Wisconsin; a system which physicians and other healthcare providers worked to establish in 1975 to deal with the growing number of malpractice actions.

At its June meeting the Medical Liability Committee:

- Voted to remain opposed to two legislative proposals introduced by the Wisconsin Academy of

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

Trial Lawyers which would extend the current statute of limitations for initiating a malpractice action. Assembly Bill 327 would change the statute to allow a malpractice action to be brought within three years of "discovery" of a malpractice incident. Assembly Bill 326 contains a "limited discovery" rule and would allow action to be brought within three years of "occurrence" or one year from discovery, but never to exceed six years from occurrence. Currently, Wisconsin law says an action must be initiated within three years of occurrence of the incident. The Committee felt that a change in the statute would have a negative impact on the already unstable area of malpractice insurance rates.

- Opposed AB 654, a bill allowing attorneys to consider all future medical expenses in determining their contingency fee for their legal services. The Committee said the bill would give attorneys added incentive to ask for higher awards and would give attorneys money that has been set aside for the medical expenses of the patient.

- Reviewed two bills which were introduced at the Committee's request: AB 637 would require that any witness in a malpractice action be licensed and practicing in Wisconsin and must prove he or she is knowledgeable in the medical issue at hand; AB 638 would permit physicians and patients to enter into voluntary binding arbitration agreements in malpractice actions.

Dr Lubitz reelected GAC chairman

At its June 13 meeting the Governmental Affairs Commission reelected Joseph M Lubitz, MD, Oconomowoc, chairman, and J D Kabler, MD, Madison, vice-chairman. ▪

News You Can Use

Study says 'rationing' necessary to cut healthcare costs. A recent Brookings Institute study concludes that medical costs will continue to skyrocket as long as Americans and their government expect to do everything possible for the sick. The study further suggests that if the nation really wants to cut healthcare costs, it will have to seriously consider "rationing" healthcare. Louise Russell, a senior fellow at Brookings who conducted the study, said efforts to hold down costs by simply eliminating waste and fraud will not succeed because they do not come to grips with the basic cause of growth in medical costs—"the belief that no one should have to forego medical care that might save his life or preserve his health because he cannot afford to pay." "In the emotionally charged atmosphere of medical care, the momentum of new technology often puts the burden of proof on those who question the evidence for it, rather than on those who propose it," Russell said.

A brochure, "Alcohol and Your Unborn Baby" (in English and Spanish versions), published by the State Medical Society of Wisconsin for physicians and patients now is available in quanity by writing to:

The Communications Department
State Medical Society of Wisconsin
P. O. Box 1109
Madison, Wisconsin 53701

Prepared and distributed by the State Medical Society of Wisconsin

Health Services

DOUG NELSON, Director
Health Services Division

Dr Walter Schwartz, Wauwatosa, Maternal-Child Health chairman

Meeting in Madison June 8, the State Medical Society's Maternal and Child Health Committee re-elected Walter R Schwartz, MD, Wauwatosa, chairman, and Curtis R Weatherhogg, MD, Madison, vice-chairman of the Committee. In other action, the Committee:

- Directed staff to proceed with development of health education/awareness flyers on smoking during pregnancy and drug abuse/use during pregnancy similar to the Fetal Alcohol Syndrome flyer.
- Endorsed the instillation of silver nitrate into the eyes of a newborn infant within a reasonable period of time after delivery. The Committee's position was based on current medical practices and the best known method of preventing communication of venereal disease.
- Will invite a representative from the State Department of Public Instruction to the Committee's next meeting to discuss why school health education in the State seems to be in low profile.

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

Women's health issues conference

Elsewhere in this issue is a special article that summarizes the recent conference on "Women's Health Issues," cosponsored by the State Medical Society of Wisconsin and the Governor's Commission on the Status of Women. Major recommendations developed from the conference are included. ■

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Final classification of the less-than-effective indications requires further investigation.

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Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.
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County Societies

Dane CMS sponsors healthcare cost seminars

The cost of health care is a topic that gets front page attention in almost any newspaper in the country. Various entities battle in the press, in private offices, and in the halls of government over who is to blame for the high cost of health care and what should be done to bring this monstrosity under control. As the "war" escalates, the consumer of health care continues to be caught in the cross fire. Rarely is there a demilitarized zone where the consumer can hear all sides, ask questions, and decide what role he plays, if any, in coralling this monster.

This past spring, Dane County Medical Society and Madison General Hospital located a neutral front in Madison at Bolz Auditorium and cosponsored a three-part series entitled, "The Consumer and Health Care Costs: Can You Afford to be Sick?" The series focused on these issues: the factors that influence health care costs, how consumers cope with health care costs, and what the consumer can do to help control those costs.

Seminar I of the series was devoted to factors that influence health care costs. Three different perspectives were given: (1) a physician's, (2) a hospital finance director's, and (3) a professor of economics.

Thomas Ansfield, MD, presented the physician's viewpoint. He emphasized the importance of developing and maintaining healthy lifestyles in order to minimize use of the health care system, and, therefore, as a means of reducing the amount of dollars spent on health care. Doctor Ansfield also indicated that there are consumers who are apt to over-utilize the health care system because they are covered by insurance and aren't aware of the costs for most services.

Ralph Andreano, former administrator of the Division of Health, echoed Doctor Ansfield's contention regarding consumer over-utilization of the system. He stated that there is a definite need for regulation, "left alone, the private health care system has produced too much of some things and too little of other things."

The second session, "How Consumers Cope with Health Care Costs" covered several topics: health insurance, health maintenance organizations, the Health Maintenance Plan of Dane County, Medicare, Medicaid, and national health insurance. Robert Beilman, MD, Past President of Dane County Medical Society, spoke on the basic principles of a Health Maintenance Organization and the Health Maintenance Plan, their differences and their effects on health care costs. Doctor Beilman, who assisted in drafting the federal legislation pertaining to Health Maintenance Organizations, stressed the need for a payment mechanism that is based upon the health maintenance approach to health care.

Speaking on handling consumer complaints regarding health insurance and guidelines for purchasing health insurance at the third session was former Insurance Commissioner, Harold Wilde. Mr Wilde pointed out that until there are financial incentives built into the health care system for providers to reduce the health care bill, costs will continue to rise.

Walter Washburn, MD, suggested ways in which the consumer could more efficiently use the health care system, and more specifically, the physician's office. He emphasized the importance of developing a good physician-patient relationship to help patients feel at ease when asking questions regarding his or her health care. Doctor Washburn encouraged the attendees to play an active role in their health care.

The Board of the Dane County Medical Society applauded the series as a successful community health education venture. J D Kabler, MD, President of the Dane County Medical Society, said that, "This type of program represents one of many ways in which organized medicine can increase its active involvement in community affairs." With this as a stepping stone, Dane County Medical Society will be planning similar programs in the near future. The Board has already indicated its desire to sponsor other community education sessions on a variety of topics. ■

Prepared by Beth Jones, Community Health Coordinator, Health Services Division, State Medical Society of Wisconsin.

You, too, can have a good media relations program

Medicine is in dire need of good public relations at this time when assault after assault is being made on the profession in the name of the public. Accordingly, the AMA has just come out with the third printing of its booklet, "You, Too, Can Have a Good Media Relations Program," which is beamed especially at county medical societies. Further details of this AMA program appeared in the June BLUE BOOK issue at page 21. ■

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Jack A Killins, MD,* Green Bay, recently was awarded the University of Wisconsin-Green Bay's Chancellor Award for his service to the institution. Doctor Killins, a general surgeon, is currently president of the Green Bay Clinic and has served as president of the Wisconsin Surgical Society and the Brown County Medical Society, and is on the medical staffs of Bellin Memorial and St Vincent hospitals. He earned his medical degree from the University of Nebraska and a master of science degree in surgery from the University of Minnesota. Doctor and Mrs Killins have been enthusiastic friends and supporters of the University since its establishment. Doctor Killins has been a member of the Board of Directors of the UW-Green Bay Founders Association and the University's principal community support organization since 1973.

Doctor Killins

Felicisima B Balverde, MD, Little Chute, recently opened his medical office in the practice of obstetrics/gynecology. A graduate of the University of Santo Tomas, The Philippines, Doctor Balverde served his residency at Mount Sinai Hospital, Chicago, and Northwestern University Hospital in Evanston. He previously had practiced in Browns Valley in the western portion of Minnesota.

Karl J Klein, MD,* West Bend, recently opened his office for the practice of obstetrics/gynecology in the Oakbrook Medical Complex. Doctor Klein graduated from the University of Kentucky Medical School and served his internship and residency in Grand Rapids, Mich. He served in the United States Army for two years and most recently had a medical practice in Racine.

Alvin Krug, MD, Brookfield, has joined the Falls Medical Group SC, Menomonee Falls, as an orthopedic surgeon. He graduated from the Medical College of Wisconsin in 1973 and served his internship and residencies at University Affiliated Hospital, Irvine, Calif.

S K Madan, MD, Edgerton, has become associated with the Shearer-Cohen Clinic. He has served on the Edgerton Hospital medical staff since 1978 and has assisted in managing the Intensive Care Unit in Edgerton. Doctor Madan served an internship at Mercy Hospital, Des Moines, Iowa, and also underwent three years of residency in internal medicine at Wayne State University Hospitals, Detroit, Mich. His wife, Dr Nalini Madan, also is associated with the Clinic as a pediatrician.

Bruce Griswold, MD, West Bend, will begin his association with the Frankow and Grundahl Clinic in August. A 1976 graduate from the Medical College of Wisconsin, he served his family practice residency at St Michael's Hospital, Milwaukee.

Larry Gill, MD, West Bend, a graduate from the University of Oregon Health and Science Center in Portland will become associated with the Frankow and Grundahl Clinic in September. He served his internship at St Michael's Hospital, Milwaukee, where he also is completing his family practice residency.

Richard C Oudenhoven, MD,* Green Bay, recently was admitted to membership in the International Society for the Study of the Lumbar Spine at its 6th annual meeting in Goteborg, Sweden.

Kenneth J Billings, MD, Marshfield, recently became associated with the medical staff of the Marshfield Clinic in the practice of radiology. Doctor Billings graduated from Tufts University Medical School, Medford, Mass, and served his internship and residency with the United States Navy at the Philadelphia Regional Naval Medical Center. Prior to locating in Marshfield, Doctor Billings had practiced with the Holzer Medical Center, Gallipolis, Ohio.

Michael P McQuillen, MD,* Milwaukee, professor and chairman of the Department of Neurology at the Medical College of Wisconsin, has been elected to membership in The Johns Hopkins Society of Scholars. A diplomate of the American Board of Psychiatry and Neurology, fellow of the American Academy of Neurology and member of the American Neurological Association, Doctor McQuillen came to The Medical College of Wisconsin in 1974 to set up the Department of Neurology.

Doctor McQuillen

Jordan A Sennett, MD,* Bayside, recently opened his medical practice of internal medicine and endocrinology in Grafton. A graduate of Harvard Medical School, he is an assistant clinical professor of medicine at the University of Wisconsin Medical School-Madison, and is a member of St Michael and St Alphonsus hospital medical staffs.

Rudolph C Hecht, MD,* Madison, recently presented his official consular credentials to Madison's Mayor Joel L Skornicka. Doctor Hecht is medical director of the Family Practice Clinic-Northeast, and Honorary Consul of Mexico in Madison and Dane County.

Frederick J Hofmeister, MD,* Elm Grove, recently was presented with a special Award from the Salvation Army. Doctor Hofmeister, who has served 43 years on the Salvation Army's Advisory Board, was given the award in recognition of untiring efforts and compassion for the individual in need of love, care, and understanding and for a life of exemplary service to his community and to The Salvation Army.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1979

1 WisPRO Review and Evaluation Committee
5 Dane County Medical Society Board of Trustees
5 Wisconsin Surgical Society
6 SMS and WHA Staff Meeting
7 SMS Commission on Health Planning
8 SMS Committee on Maternal and Child Health
8 *Health Planning Conference (Concourse Hotel, Madison)*
11 Health Planning Council-Physicians Task Force
13 SMS Committee on Federal Legislation
13 SMS Commission on Governmental Affairs
15 SMS Physicians Alliance Commission
15 *Aesculapian Society Meeting (Museum, Prairie du Chien)*
16 *Editorial Board of Wisconsin Medical Journal (Maple Bluff Country Club, Madison)*
20 Madison Indepth Planning Meeting
20 SMS Committee on Alcoholism and Other Drug Abuse
21 WisPRO Review Coordination Conference
21 Food and Nutrition Services Advisory Committee
22 *Executive Committee of SMS Council (Madison Club, Madison)*
22 SMS Committee on Mental Health
26 SMS Committee on Aging and Extended Care Facilities
28 SMS Committee on School Health

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis. ■

Doctor Waldren

H Mowat Waldren, MD,* West Allis, recently was installed as president of the Marquette- Medical College of Wisconsin Alumni Association. Doctor Waldren, a 1957 alumnus, is a fellow of the American College of Obstetrics and Gynecology.

Ralph Tauke, MD, Tigerton, recently joined the Tigerton Clinic. A 1974 graduate from the University of Iowa Medical School, Doctor Tauke served his residency in internal medicine at the University of Nebraska.

Sharon Smith, MD, Burlington, recently became associated with the Burlington Medical Center. Doctor Smith graduated from Albert Einstein College of Medicine and completed her residency training at Midland Hospital, Michigan, and Imogene Bassett Hospital in New York.

Philip E Veenhuis, MD,* Brookfield, recently was appointed director of medical education at Milwaukee Psychiatric Hospital. Doctor Veenhuis also is director of continuing education for the Department of Psychiatry and Mental Health Sciences of the Medical College of Wisconsin, Milwaukee.

Daniel J McCarty, MD,* Milwaukee, professor and chairman of the Department of Medicine at the Medical College of Wisconsin, recently was installed as president of the American Rheumatism Association section of the Arthritis Foundation. He has been a member of the Foundation's Board of Trustees and House of Delegates since 1974.

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Steven Chojnacki, MD,* Milwaukee, recently was named Alumnus of the Year by the Marquette-Medical College of Wisconsin Alumni Association. He is a 1937 graduate of the medical school and is an associate clinical professor of family practice. Doctor Chojnacki is past president of the Milwaukee Academy of Family Practice and the Milwaukee Catholic Physicians' Guild and also is former chief-of-staff of St Francis Hospital.

Doctor Chojnacki

Doctor Fink

Jordan N Fink, MD,* Milwaukee, recently was named to the executive committee of the American Academy of Allergy. The 1979 executive committee was announced at the conclusion of the 35th annual meeting of the Academy held in New Orleans, Louisiana.

John J Czajka, MD,* Franklin, recently was honored by the Sertoma Clubs of the Wisconsin and Illinois Region. He was selected by the Sertoma Club of Milwaukee to receive its annual Service to Mankind Award for his involvement with the Guadalupe Medical Clinic in the Spanish-speaking community of Milwaukee. Doctor Czajka, pediatrician, is associated with the Forest View Pediatrics, SC, in Hales Corners.

John R Murphy, MD, after 50 years of practice of internal medicine in New York City, has retired to Wisconsin. Doctor Murphy graduated from the College of Physicians and Surgeons, Columbia University, New York, in 1928. Doctor Murphy and his wife are now living at 1029 West Jackson St, Milwaukee 53202. Their son, Jerome, is a pediatric neurologist at Milwaukee Children's Hospital and The Medical College of Wisconsin. ■

Holy Cross Hospital, Merrill, has reelected Geoffrey C Kloster, MD* as its president of the medical staff. Michael K Mikkelson, MD* was renamed vice-president, and Muhammad Y Ahmad* was reelected secretary-treasurer. All the physicians were elected to serve one-year terms.

Safooh Allouch, MD, Durand, recently opened his medical practice in Pepin. He studied medicine at Damascus Medical School in Syria and completed his internship at Mercy Hospital, Buffalo, New York. He served five years of residency training in general surgery and one year in vascular surgery at Hackensack Hospital in New Jersey. ■

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News Highlights

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

The Jackson Clinic, Madison, recently was awarded a two-year $20,000 grant to study and improve the quality and cost-effectiveness of patient care rendered in a modern ambulatory healthcare delivery system. The grant, funded by the W K Kellogg Foundation and St Louis Park Medical Center Research Foundation, Minneapolis, Minn, is one of ten grants which will be awarded to ambulatory care clinics across the country. Sanford Mackman, MD,* president of the Clinic, said, "Monies provided by the grant will be used to implement a quality assurance program designed to explore problem areas within the patient care system, and then develop and implement solutions for the problems." According to the Clinic's medical director, Blake E Waterhouse, MD,* the experiences of the Jackson Clinic Quality Assurance Program will be combined with that of the St Louis Park Medical Clinic and the other nine participating clinics across the country. This will be done in an effort to establish the effectiveness of ambulatory outpatient review processes and used by all medical groups or clinics to systematically improve the quality of medical care being rendered.

Blue Cross of Milwaukee, recently at its annual meeting, paid tribute to James D Michael, MD,* Sheboygan, as he marked five years of service as a member of the Blue Cross board of directors. Doctor Michael, an internist, originally was elected to the Blue Cross board in 1974 and currently serves on the board's professional relations committee.

The University of Wisconsin Medical School, Madison, has been awarded grants from two foundations to develop programs for teaching cost containment and quality assurance. Jonathan Elion, MD, assistant professor of medicine, was awarded a $32,000, one-year grant by the Faye McBeath Foundation, Milwaukee, to develop an innovative computer teaching program, and James E Davis, MD, fellow in family medicine and practice, received a $20,000, one-year fellowship in medical education from the National Fund for Medical Education. Hartford, Conn. Doctor Elion graduated from the Brown University Medical School, Providence, RI in 1975 and was a resident in medicine at the University of Wisconsin until 1978 and an instructor in medicine from 1978-1979. Doctor Davis is a 1975 graduate of George Washington University School of Medicine, Washington, DC, and served his residency in family medicine and practice at the University of Wisconsin, where he was chief resident from 1977-1978.

Necedah Clinic opened May 7, climaxing a cooperative effort of the hospital administrator, physicians in Adams and Mauston, and the Necedah Area Community Health, Inc. The clinic is open on Mondays and Fridays with a nurse practitioner providing services for which s/he is trained when a physician is not present. Clinic physicians are: Martin Janssen, MD;* MB Mirza, MD;* Rahmotolah Simani, MD;* R Sankaran, MD;* and M Esmaili, MD.*

St Joseph's Hospital, Wauwatosa, recently announced new officers of its medical staff. The MDs appointed are: William V Baker,* president and Anthony F Cafaro,* secretary-treasurer. Representing the obstetric department on the executive committee is John J Brennan* and representing the internal medicine department is Thomas P Driscoll.*

Milwaukee Psychiatric Hospital's board of directors, at its annual meeting, elected members to newly created posts of chairman and vice-chairman and named a new president. Benjamin C Bugbee, who has served as president since 1974, was elected chairman of the board; Orin Purintun, who previously served as vice-president, was elected vice-chairman; and Gerald E Schley, executive director of the hospital, was elected president. Milwaukee Psychiatric Hospital is observing its 95th year of continuous operation on the original site overlooking the "Village" area of Wauwatosa. ■

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report

for Wisconsin Physicians

Volume VIII, Number 4 July, 1979

PROFESSIONAL RECORDS SERVICE

Professional Records Service (PRS) is a WPS service bureau which provides a professional, reliable, and economical computerized practice management and accounts receivable information system to physicians. PRS has provided these services since 1973, based on a system researched and developed in 1966, and currently lists over 300 physicians with over 100,000 active accounts at many separate facilities. In 1978, PRS processed in excess of $48,850,000 in charges and payments for clients.

The PRS computer service system was developed specifically to meet the continually increasing demands upon the clerical and administrative operations of a modern medical practice. PRS provides support for accounts receivable record keeping, statement and insurance billing, and supplies necessary income analysis and management reports.

The services now being offered by PRS include both direct on-line service and batch service. The PRS on-line system is based upon the use of Cathode Ray Terminals (CRTs) directly linked via telephone lines to the PRS computer. The on-line service offers the physician's office direct access to patient information and accounting transactions related to a patient.

In addition to the availability of information via the on-line access to the computer, PRS also provides Patient Statements, Insurance Forms, Patient Recall Messages, and many other forms of management reports. Such reports enable the physician's or clinic's office to analyze charges and payments, in detail by physician, or in total for the entire medical practice. The features of the PRS on-line system enable the physician's staff to eliminate many time consuming routine bookkeeping activities.

Among the services provided by the PRS on-line system are:

--All terminal(s) and associated telecommunications equipment installed at the physician's office location, including service on all equipment.

--Training of office staff by qualified PRS personnel.

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--All computer processing

--Computer preparation of statements and insurance forms.

--Folding, stuffing and mailing of statements with return envelopes.

--Delivery costs of all system output needed by the office and prepared by PRS.

--All practice management reports now generated by the system on a weekly or monthly basis, plus any other reports mutually agreed upon.

--Follow-up training and support services.

--Any future modifications or improvements made to the present system.

PRS also provides an alternative batch system available to the office for which an on-line arrangement may not be appropriate. The batch system provides all the features of the on-line system except the immediate accessibility of information via CRT. Instead, PRS does all data entry and provides current account information on a weekly basis.

Further information on the PRS system may be obtained from a PRS representative, (608)221-4711, extension 482.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

LOCATING THE PROPER DEPARTMENT

No one appreciates telephoning a large organization for specific information and being transferred from department to department. If you read the following information, the chances of this happening to you when you call WPS will be greatly reduced.

WPS has centralized inquiry services areas for each of its major claims operations. In most cases, any questions you might have about coverage or claims for patients whose claims are processed by WPS will be answered by the appropriate inquiry services area.

Therefore, the following charts are designed to help you quickly locate the proper WPS area to answer your questions.

If You Have A Question About...	Call...	And...
Medicare Part B	(608)221-4711	Ask for **Medicare Inquiry Services**
Champus	(800)362-7220 (toll-free)	Ask for **Champus Inquiry Services**
Claims or Coverage for WPS Policyholders (excluding State of Wisconsin employees)	(608)221-4711	Ask for **WPS Inquiry Services**
Claims or Coverage for State of Wisconsin Employees having WPS Insurance	(608)221-4255	Ask your question. This is a direct line into **WPS State Inquiry Services.**
Coordination of Benefits (two or more insurance companies)	(608)221-4711	Ask for **Coordination of Benefits**
Workers Compensation	(608)221-4711	Ask for **Workers Compensation**
Subrogation (third party liability)	(608)221-4711	Ask for **Subrogation**
A WPS Provider Number	(608)221-4711	Ask for **Central Provider Code Unit**

Having the correct address on claims and correspondence mailed to WPS is also important to avoid delays. Consequently, consult the following mailing chart.

If You Have...	Send To...
Claims for all WPS Policyholders	WPS Claims, P.O. Box 8190 Madison, WI 53708
Correspondence Regarding All WPS Policyholders	WPS Inquiry Services, P.O. Box 8190 Madison, WI 53708
Formal Referrals Under The Health Maintenance Program (HMP)	WPS-HMP, P.O. Box 7932 Madison, WI 53707
Claims and Correspondence Involving Medicare Part B	Medicare, P.O. Box 1787 Madison, WI 53701
Champus Surgical-Medical Claims	WPS-Champus, P.O. Box 7953 Madison, WI 53707
Champus Inquiries or Other Correspondence	WPS-Champus, P.O. Box 7927 Madison, WI 53707

WPS is always looking for more efficient ways to be of service. The preceding information is another element of this effort.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 30¢ per word, with a minimum charge of $12.00 per ad. BOXED AD RATES: $15.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

Physicians Exchange

PHYSICIAN(S) INTERESTED IN family practice to locate in Baldwin, Wis. Excellent hospital facilities located adjacent to Clinic. Offers excellent family environment and a variety of recreational activities. 40 minutes east of St Paul, Minn. Contact Gordon Palmer. Admin, Baldwin Community Hospital, Baldwin, Wis 54002. Tel: collect 715/684-3311. 7-9/79

GONZALEZ MEDICAL CENTER is seeking a pediatrician who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, telephone 414/344-1120; 414/671-5410; 414/476-8624. 7/79

THE WAUSAU MEDICAL CENter, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology
- Dermatology
- Family Practice for satellite clinic
- Neurology
- Orthopedics
- Otolaryngology
- Radiology

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, write John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 3tfn/79

WANTED: TWO FAMILY PHYsicians preferably ABFP for association with the Family Medical Center, Sheboygan, Wisconsin. Please call or write: Martin A Rammer, MD, 1930 N 8th St, Sheboygan, Wis 53081; phone 414-457-5016. 5tfn/78

OB-GYN: IMMEDIATE OPENing with 9-man, multispecialty group. To join present Ob-Gyn, four internists, two pediatricians, and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing—pension plan. Young group. Contact James L Algiers, MD or Clinic Manager, Parkview Medical Associates, Ltd, 1004 East Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/79

MULTISPECIALTY GROUP OF 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Dermatologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

GENERAL INTERNIST AND family practitioner to join multispecialty group of nine physicians, in suburban community, 20 minutes from Milwaukee. First year salary open, opportunity for corporate membership after one year. Fringe benefits include: malpractice insurance, profit sharing, medical reimbursement plan, life insurance, disability benefits, and more. Contact George V Murphy, MD, South Milwaukee Clinic, 100 15th Ave, South Milwaukee, Wis 53172. 6-7/79

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

PHYSICIANS—WE SAVE YOU TIME AND KEEP YOUR CAREER LOCATION SEARCH COMPLETELY CONFIDENTIAL

We're all medical professionals ourselves so we recognize outstanding opportunities. Tell us your geographic and position choices and salary expectations. We'll match them with the career opportunities we have available in Wisconsin as well as nationwide.

Contact Donna Herschleb, RN
HORNER MEDICAL PLACEMENTS
802 W Broadway, Suite L-6M
Madison, WI 53713
Tel: 608/222-1616
Licensed Employment Agency
1tfn/79

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1979 Wisconsin

July 29-Aug 1: The Second Annual *Nuclear Cardiology for the Practicing Physician* at Playboy Club Resort, Lake Geneva, Wis. Info: Dr Jagmeet S Soin, Division of Nuclear Medicine, The Milwaukee County Medical Complex/The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5968.

Aug 2-3: 1st Annual Respiratory Critical Care Symposium, The Sheraton Inn-Madison Gateway. Info: Lyn Opelt, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Aug 23-26: Pediatric Emergencies—Update 1979, Playboy Resort, Lake Geneva. 24 hours Category I PRA-AMA. Info: EMSS (Emergency Medical Services Symposium), 3900 NW 79th Ave, #469, Miami, FL 33166. Tel: 305/592-9298.

Sep: Wisconsin Neurosurgical Society (day and location, not yet set).

Sept 8: Wisconsin Allergy Society Annual Meeting, Pioneer Inn, Oshkosh. *Pulmonary Function,* by Reuben Cherniak, MD, Denver, CO, and *Newer Development in Stinging Insect Therapy,* by Martin Valentine, MD, Baltimore, MD. 4 hours CME credit. Info: Morton M Soifer, MD, 707 West Glencoe Pl, Milwaukee 53217. Tel: 414/351-4445.

Sept 13-15: Wisconsin Society of Internal Medicine, Playboy Club, Lake Geneva.

Sept 13-15: Wisconsin Regional Meeting, American College of Physicians, Lake Geneva Playboy Club, near Milwaukee. Designed to bring physicians up-to-date on late developments in the field of internal medicine. Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physician's Recognition Award in Category I. In charge of planning for the ACP's Wisconsin Regional Meeting is Charles L Junkerman, MD, who serves as the medical specialty society's representative in Wauwatosa. Info: Charles L Junkerman, MD FACP, 831 N 66th St, Wauwatosa, Wis 53213.

Sept 14-16: Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Sept 19: One-Day Seminar for Family Physicians, St Vincent Hospital, Green Bay

Sept 20-22: *Midwest Cancer Seminar,* The Concourse, in Madison, sponsored by Wisconsin Clinical Cancer Center and others. See details elsewhere in this section.

Sept 24: Wisconsin Clinical Cancer Center's Second Annual Midwest Oncology Nursing Conference, at The Wisconsin Center, in Madison. See details elsewhere in this section.

Oct 17: One-Day Seminar for Family Physicians, Bellin Memorial Hospital, Green Bay.

Oct 17-19: Seminar/Workshop on Genitourinary Radiology, The Olympia, Oconomowoc. Approved for Category 1 credit of PRA-AMA. Info: Lyn Opelt, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Nov 9: 18th *Annual Medical-Legal-Industrial Symposium: Cancer and Industry,* Pfister Hotel, Milwaukee. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee 53201. Tel: 414/289-8200.

Nov 14: One-Day Seminar for Family Physicians, St Vincent Hospital, Green Bay.

1979 Neighboring

Sep 16-20: American College of Radiology, Chicago.

See separate listing of **University of Miami School of Medicine** courses elsewhere in this section.

Sept 28: Hand Symposium, Bethesda Lutheran Medical Center, St Paul, Minn. See details elsewhere in this section.

Oct 13-17: Indiana State Medical Association, Sheraton West, Indianapolis. Info: D F Foy, 3935 N Meridian St, Indianapolis, IN 46208. 248. Price: $9.00.

1979 Others

Aug 2-5: International Doctors in Alcoholics Anonymous Annual Meeting. Holiday Inn at the Embarcadero, 1355 North Harbor Dr, San Diego, CA 92101 (specify IDAA Meeting), or call 800/453-5555. For further information, contact Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511. Tel: 216/782-6216.

Aug 13-15: Aspen Seminar—**Medical Staff law and bylaws.** Be prepared for the new JCAH guidelines. At The

1979 Others

Sept 15-16: Workshop on Practice Management, presented by AAFP Commission on Health Care Services' Subcommittee on Practice Management in conjunction with the Iowa Chapter. Program carries 11 1/2 hours of Prescribed AAFP continuing education credits. Registration fee for physicians, office managers, and aides is $100. Further info: Chet Watts, AAFP Dept of Registration and Housing, 1740 West 92nd St, Kansas City, MO 64114, or call him at 1-800-821-2512.

Oct 1-5: *First International Congress of Institutional Clinical Pathology* in Mexico City. The WMJ office has details.

Oct 8-11: American Academy of Family Physicians Scientific Assembly, Atlanta, Ga.

1979 AMA

July 22-26: AMA House of Delegates sessions, in Chicago. (The annual convention of 1978 was the last to combine a meeting of the House of Delegates and the Scientific Program.)

MIDWEST CANCER SEMINAR

September 20-22, 1979

The Concourse in Madison

Sponsored by Wisconsin Clinical Cancer Center of the University of Wisconsin, Center for Health Sciences, Madison; Midwest Children's Cancer Center of the Medical College of Wisconsin, Milwaukee; American Cancer Society —Wisconsin Division Inc, Madison; Eastern Cooperative Oncology Group; and Cancer Education Committee of Wisconsin Clinical Cancer Center

CME information: As an organization accredited for Continuing Medical Education, the Wisconsin Clinical Cancer Center certifies that this CME activity meets the criteria for twelve (12) credit hours in Category I of the PRA-AMA. Also acceptable for 12 prescribed hours by the AAFP.

Objectives: To bring to the practicing physician current knowledge regarding screening, diagnosis, and management of major malignancies. To emphasize the practical application of new methodologies in the management of GI, GYN-GU, HEMATOLOGIC, and LUNG Cancer.

Program highlights:

- **Screening for Cancer in Clinical Practice:** Critical Concepts/High-risk Patients/Tests for Breast, Colon-Rectum, Cervical and Lung Cancer/Carcinogens in Our Environment—How Much Risk?/Thyroid Cancer Following Head and Neck Irradiation: An Approach to Patients at Risk/Post-menopausal Estrogens —Risks and Benefits
- **New Approaches to Male GU Cancer:** Combination Chemotherapy for Disseminated Testicular Cancer/Treatment of the Hormonally Unresponsive Patient with Carcinoma of the Prostate
- **Small Cell Lung Carcinoma:** Results of Therapy—Small Cell Undifferentiated Lung Cancer/Role of Radiotherapy in the Treatment of Small Cell Carcinoma of the Lung
- **Gastrointestinal (Large Bowel and Pancreas) Cancer:** Surgical Management and Staging of Large Bowel Cancer/The Evolving Role of Radiotherapy in the Management of Gastrointestinal Malignancies/Update of Current Adjuvant Studies
- **Hematologic Malignancies:** Childhood Acute Lymphocytic Leukemia—Progress and Problems/Stage I-II Non-Hodgkin's Lymphomas: Improved five-year survival after combined radiotherapy-chemotherapy
- **Keynote address: Hodgkin's Disease:** *Henry S Kaplan, MD* Maureen Lyles D'Ambrogio Professor of Radiology and Oncology, and Director, Cancer Biology Research Laboratory, Department of Radiology, Stanford University Medical Center

25th ANNUAL FALL CANCER CONFERENCE

Saturday, September 22

- **Breast Cancer:** Primary Management of Breast Cancer/Adjuvant Chemotherapy in Operable Breast Cancer/Patient Selection for Hormonal Therapies
- **New Developments in Cancer Therapy:** New Approaches in Radiation Oncology/Interferon: Rationale for use in human neoplasia/Priorities and Direction in Professional Education

Wisconsin-UCLA Football Game, Camp Randall Stadium

Registration fee: $50. Registration deadline: September 15. Further info: **Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705**

18th ANNUAL MEDICAL-LEGAL-INDUSTRIAL SYMPOSIUM

Friday, November 9, 1979

Hotel Pfister/7th Floor
Milwaukee, Wisconsin

Cancer and Industry

Program

am

8:00 Registration

9:00 Welcome / Daniel A Kane, Executive Vice-President, Mount Sinai Medical Center

9:05 Introduction/Sidney K Wynn, MD, Symposium Chairman, Mount Sinai Medical Center

9:10 The Politics of Cancer/Samuel S Epstein, MD, Professor of Occupation and Environmental Medicine, School of Public Health, University of Illinois

10:35 Cancer of the Lung as Related to Industry/Norbert Enzer, MD

11:05 Surveillance Studies in Industry/Sidney Shindell, MD,LLB, Professor and Chairman Department of Preventive Medicine, MCOW

11:30 Metals Intoxication as Related to Cancer/Carl Zenz, MD, School of Occupational Medicine

pm

1:30 Role of RN in Early Detection of Cancer/Judy Hayes Bernhardt, Associate Professor of Occupational Health Nursing, School of Nursing, University of Wisconsin-Milwaukee

1:50 Compensability of Occupational Cancer/Attorneys Leonard S Zubrensky and John H Jones; and Hugh Russell, Workers Compensation Division

2:50 Question and Answer Period

Further information contact Mount Sinai Medical Center, Medical Center Relations, PO Box 342, Milwaukee, Wisconsin 53201.

1979 Others

continued

Abbey on Lake Geneva, Fontana, Wis (ph 414/275-6811). Two and one-half days. Tuition: $335. Register with Registrar, Aspen Systems Corporation, 20010 Century Blvd, Germantown, Md 20767; or call 301/428-0700.

Aug 19-25: *First US Medical Games & Sportsmedicine Conference,* at the University of Southern California in Los Angeles. Physicians, dentists, podiatrists, physical therapists, pharmacists, and veterinarians will compete in Olympic-style events and attend a conference on sportsmedicine. *The Physician Sportsmedicine* medical journal is sponsoring the conference to promote healthcare. The journal's editor is Dr Allan Ryan, formerly of the University of Wisconsin-Madison, and he also is president of the US Medical Games. Among keynote speakers are Dr William Clancy, an orthopedic surgeon and the head team physician at the University of Wisconsin-Madison. He is an authority on running injuries and a consultant to runners and Olympic teams worldwide. Info: McGraw-Hill Conference Exposition Center, 1221 Avenue of the Americas, New York, NY 10020; phone 212/997-3591.

Aug 27-31: American Institute of Ultrasound in Medicine (AIUM) will conduct its 24th Annual Meeting in conjunction with the 8th Annual Meeting of the American Society of Ultrasound Technical Specialists, in Montreal, Canada. Scientific sessions, scientific exhibits, poster sessions, and one of the largest ultrasound instrumentation exhibits in the United States. Info: AIUM/ASUTS Montreal '79, 6161 North May Ave, Suite 278, Oklahoma City, Okla 73112 (405/840-3721).

Hand Symposium

Third Annual John R Sebald Hand Symposium sponsored by

Bethesda Lutheran Medical Center—**St Paul, Minn**

Friday, September 28, 1979

in O'Shaughnessey Education Center at the College of St Thomas in St Paul

Featured speakers:

- *Richard Smith, MD,* Chief of Hand Surgery Services, Massachusetts General Hospital, Boston
- *Joseph Kutz, MD,* Clinical Professor of Surgery, University of Louisville, Louisville, Ky
- *Allen Van Beek, MD,* Associate Professor of Plastic and Reconstructive Surgery, University of Southern Illinois, Springfield, Ill

Application has been made for Category I credits, AMA, AAFP, and Minnesota Nurses Association continuing education credit.

Afternoon workshop for physical and occupational therapists to emphasize rehabilitation and splinting methods for diseases and deformities in the hand.

- *Diane Accurso, OTR*
- *Pat Schober, OTR*

Bethesda Lutheran Medical Center

For information on registration contact **Tim Hanson, Associate Administrator, Bethesda Lutheran Medical Center, 559 Capitol Blvd, St Paul, Minn 55103; 612/221-2395.**

7-8/79

University of Miami School of Medicine

Critical Care Symposium: Sept 29-30, 1979. Hyatt Regency O'Hare, Chicago, IL. Course Hours, 10 AMA Category 1.

Intensive Care Seminar: Nov 17-18 1979. Hyatt Regency Washington DC. Course hours, 10 AMA Category 1.

Current Concepts in Intensive Care for Neurological Trauma and Disease: Jan 24-27, 1980. Americana of Bal Harbour, Miami Beach, Fl. Course hours, 22 AMA Category 1.

A Neurological Update 1980: Jan 27-Feb 1, 1980. Americana of Bal Harbour, Miami Beach, Fl. Course hours, (Child, 6) (Adult, 24) (Both, 30) AMA Category 1.

Basic Neurology for Psychiatrists and Generalists: Mar 3-7, 1980. Konover Hotel, Miami Beach, Fl. Course hours, 32 AMA Category 1.

Current Clinical Concepts in Otolaryngology: Mar 27-29, 1980. Americana of Bal Harbour, Miami Beach, Fl. Course hours, 15 AMA Category 1.

Heptobiliary Disease: Mar 27-29, 1980. Americana of Bal Harbour, Miami Beach, Fl. Course hours, 15 AMA Category 1.

8th Annual Intensive Care Symposium: Apr 25-28, 1980. Eden Roc Hotel, Miami Beach, Fl. Course hours, 21 AMA Category 1.

For Further Information Please Contact: Division of Continuing Medical Education D23-3, University of Miami School of Medicine, PO Box 016960, Miami, Fl 33101. Tel: 305/547-6716. 7-8/79

SMS MEMBERS
use the
IN- "WATS"
toll-free number
1-800-362-9080
to reach staff at
SMS headquarters in Madison

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1979-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1979 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

Sept 27-30: AMA "theme meeting" on "Therapeutics." In Kansas City, Mo. Includes variety of other postgraduate courses.

Oct. 12-13: *Medical Staff Leadership Seminar (Advanced)*, Resorts International Hotel, Atlantic City, New Jersey. Program outline: 1) Refinements of medical staff organization. 2) Health planning and other external constraints. 3) Alternate methods of quality assurance. 4) Maximizing leadership positions: management and leader techniques. Registration fee: $200 for AMA members, $300 for nonmembers. CME credit: 14 hours in Category 1 for PRA-AMA. Further info: Call (312) 751-6657 or write to the AMA Dept of Hospitals & Health Facilities, 535 North Dearborn St, Chicago, Ill 60610.

Nov 9-10: *Patient Safety/Risk Control Seminar*. The Breakers, Palm Beach, Florida. Course outline: 1) Recent developments in malpractice legislation and litigation; impact on medical care. 2) Professional liability insurance. 3) Physician participation in quality assurance and patient safety programs. 4) Responsibilities of the medical staff, governing board, and administration. 5) Delineation of privileges for physicians and nonphysician professionals. 6) The medical staff's potential liability for others. 7) A plaintiff's attorney looks at medical risks. 8) A defense attorney looks at medical risks. 9) The importance of medical staff influence in public and patient relations. 10) Patient complaints: frustration or medical error?. Registration fee: $200 for AMA members, $300 for nonmembers. CME credit: 14 hours in Category 1 for PRA-AMA. Further info: AMA Dept of Hospitals & Health Facilities, 535 North Dearborn St, Chicago, Ill 60610; or call (312) 751-6657.

1980 AMA

Jan 12-15: AMA Winter Scientific Meeting in San Antonio, Texas. Postgraduate courses, symposia, exhibits, and other events will be presented. (The annual convention of 1978 was the last to combine a meeting of the House of Delegates and the Scientific Program.)

WISCONSIN CLINICAL CANCER CENTER presents the Second Annual Midwest Oncology Nursing Conference

Assertive Responses to Ethical Issues in Cancer Nursing

Monday, September 24, 1979 at THE WISCONSIN CENTER
Lakeshore Room, 702 Langdon Street, Madison, Wisconsin

Program highlights:

- **Assertive Responses to Ethical Issues in Cancer Nursing**
  Melodie Chenevert, RN, BA, MSN—Author of *Special Techniques in Assertiveness Training for Women in the Health Professions*, published by CV Mosby Company of St Louis, 1979
- **Panel I**—Assertiveness Training for Cancer Patients/Staff Discussions of Ethics Arising from Supportive Group Therapy Meetings/Difficulties with Being Assertive as a Patient in the Health Care Setting/Ethics—Individual and Family Therapy
- **Panel II (Group A)—Nurses' Reactions to Caring for Cancer Patients:** Operationalizing Philosophy of Care/Emotional Responses and Ethical Issues for Staff/Grief and the Care Giver/Coping Mechanisms Used by Nursing Personnel in Terminal Care
- **Panel II (Group B)—Care of the Dying Child and Adolescent**
- **Panel III—Family Centered Approaches to Coping with Cancer:** Role of the Visiting Nurse in Care of the Cancer Patient/Ethical Issues in Home Terminal Care/Family Centered Approach to Coping with Cancer
- **Tour of Center for Health Sciences**—Oncology Departments (limited to 50 persons)

Planning Committee: Conference chairman—Edythe H Myers, RN, WCCC, Madison; Conference program coordinators—Thelma Kuenstler, RN, MSN, WCCC, Madison; Sandra Saunders, RN, MSN, University of Wisconsin Hospitals, Madison; University of Wisconsin Hospitals—Evonna Cheetham, RN, MSN, Assistant Director of Nurses, Madison.

Registration fee: $25. Registration deadline: September 7. Attendance limited to 150 persons. Send registration information and check made payable to the Wisconsin Clinical Cancer Center to: **Midwest Oncology Nursing Conference, WCCC, 1900 University Ave, Madison, Wis 53705; phone 608/263-6919.**

64th Annual International Scientific Assembly

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION

Nov 5-8, 1979—New Orleans

Designed for primary care physicians practicing in the United States and Canada. Program planned cooperatively with the Louisiana Academy of Family Physicians, Tulane University, and Louisiana State University.

Acceptable for 24 prescribed hours and 4 elective hours of credit by the American Academy of Family Physicians and the College of Family Physicians of Canada. Acceptable for a like number of credit hours toward the AMA Physician's Recognition Award.

Program consists of lectures, informal group discussions, live television, and medical movies on a variety of topics. Major emphasis in 1979 is on infectious diseases, chronic pain, nutrition, gastroenterology, endocrinology, and cardiology.

Guest lecturers include: Dr Stefan S Fajans, University of Michigan, and Dr. Harvey C Knowles Jr, University of Cincinnati, discussing "Insulin vs Oral Hypoglycemics in Treatment of Diabetes," Dr. Fredrick J Stare of Harvard University on "Nutrition—Sense and Nonsense," and Dr J Kenneth Saer, team physician for the New Orleans Saints, on "Sports Medicine." Featured speaker at the annual banquet will be Dr Robert S Eliot of the University of Nebraska on "The Management of 20th Century Stress by Physicians and Their Families." The lengthy list of speakers will include many from Tulane and Louisiana State universities and the Ochsner Clinic.

The Assembly is open to any physician in the United States and Canada. The advance registration fee is $90 ($100 at the meeting). The fee for resident physicians and ancillary health professionals is $35.

For program and registration materials, write to Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.

News You Can Use

Physicians, public, favor some form of NHI, survey shows. The majority of physicians and the public believe there is a need for national health insurance, according to results from two surveys the AMA recently commissioned. The two surveys, completed in late 1978, consisted of one conducted by the Gallup Organization sampling public opinion on healthcare issues, and another by Market Opinion Research sampling physicians' perceptions on healthcare issues. Of the physicians in favor of NHI, most felt such a program would improve access to healthcare for the poor. Other results of the two surveys were:

- Access to a physician, by the public, does not seem to be a problem. While half of the physicians interviewed perceived that patients in their communities had at least some problems finding a family physician and getting an appointment, only a small proportion of the public interviewed had a problem obtaining an appointment with a new physician.

- The public is very happy with the quality of care it receives; 87 percent of those polled were satisfied with the care they received during their last visit with the physician and with their care overall.

- Physicians are less concerned over professional liability than they were two years ago.

- More concern is expressed by physicians over government involvement in medicine and the cost of healthcare services than in previous surveys.

Negotiations seminar for salaried physicians scheduled. The American Medical Association is offering a special negotiations seminar custom-tailored for physicians employed by medical schools, public and private hospitals, medical centers, medical clinics, HMOs, and other healthcare organizations. "An Institute for Salaried Physicians" will give physicians valuable techniques on how to organize and prepare for negotiations; how to negotiate a contract; how to seek support for effective action; and how to apply pressure for resolution of disputes. The program is slated for August 10-11, 1979 at the Brown Palace Hotel, Denver, Colorado, and carries a registration fee of $150 for AMA members, $200 for nonmembers. It qualifies for 12 credit hours in Category I of the Physician's Recognition Award of the AMA.

Lung disease course scheduled. The "SUPERCOURSE V" postgraduate program on lung disease sponsored by the American Lung Association of Louisiana, Inc, and its medical section will be held November 27-December 1, 1979 in New Orleans at the Hyatt Regency Hotel. The program consists of the 16th Annual Pulmonary Function in Health and Disease Course, the 12th Annual Respiratory Disease Course, and 9th Annual Pediatric Pulmonary Course. All three programs run concurrently and are accredited by the American Medical Association in Category I for the Physician's Recognition Award on an hour-for-hour basis, and by the American Academy of Family Physicians for prescribed credit hours. Program information is available by writing John B Bobear, MD SUPERCOURSE V Chairman, American Lung Association of LA, Inc, Suite 500, 333 St Charles Ave, New Orleans, LA 70130.

A word or two on government regulations . . . A quote from McGraw Hill's *Washington Report on Health & Medicine:* "If there were ever any doubts about how numerous HEW regulations have become, the January 19 *Federal Register* dispels them. It contains 142 pages of only the *names* of regulations HEW plans to issue in 1979. A sizable number of HEW's planned regulatory initiatives deal with limiting Medicare payments to hospitals and physicians." ■

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WISCONSIN MEDICAL JOURNAL

AUGUST 1979

• Brain death • Coronary artery bypass surgery • Council acts on immunization • Herbicides and dioxin • Maternal mortality • Fetal Alcohol Syndrome Awareness Project • Expanding role of mammography • Medical liability bills

Now, two dosage forms

Nalfon®

fenoprofen calcium

300-mg.* Pulvules® and 600-mg.* Tablets

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Indianapolis, Indiana 46206

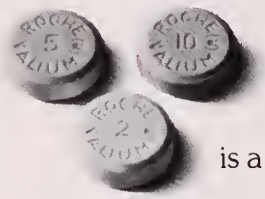
Additional information available to the profession on request.

*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

700934

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA
SEP 19 1979

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Front Page Update

Government to clamp down on amphetamine misuse. In an attempt to crack down on amphetamine abusers, the Food and Drug administration has proposed that the government withdraw its approval of amphetamines for weight reduction. If the FDA's action is successful, amphetamines could still be used for the treatment of narcolepsy and hyperactivity in children. Of the 3.3 million prescriptions written for amphetamines in 1978, 80 to 90 percent were used for weight reduction.

Governor vetoes wellness grant extension. Before he signed a biennial budget bill of more than $12-billion, Gov Lee Dreyfus vetoed an item allocating $980,000 to extend the State's wellness and prevention grant program. In deleting the grant program from the budget, the Governor said it "was a good idea whose time had not come." The program during its first year of operation has already awarded $980,000 to various wellness and illness prevention projects. More than 300 individuals and organizations submitted grant applications to the program in 1979.

Television show looks at medical marriages. Fifty-five Wisconsin members of the SMS Auxiliary were in the audience June 28 when television talk-show personality Phil Donahue devoted his program to discussing the problems unique to medical marriages. The show had a three-member panel, which consisted of Mrs William Walker of the AMA Auxiliary, Phillip Baratta Jr, MD, a psychiatrist from the University of California at San Diego, and Phyllis Savin, a patient of Doctor Baratta. Tony Sanfelippo, an attorney and SMS Auxiliary member, also was featured on the program. Other Auxiliary members from Jefferson, Milwaukee, LaCrosse, Waukesha, Winnebago, Kenosha, Fond du Lac, Walworth, and Dane counties traveled to Chicago to participate in the program. Among the issues discussed were the need for a support system among neighbors and friends because of long, unpredictable hours a doctor must put in, and the problems of being family to one who is "deified" at work. In the end, however, Auxiliary members seemed to agree that the rewards balance the sacrifices of being a doctor's spouse.

Building temperature restrictions in effect. President Carter has declared a limited state of emergency which immediately activated temperature and humidity control restrictions on all buildings, hotels, hospitals and healthcare facilities, elementary and nursery schools, and day care centers. Except for those buildings which are exempt, buildings may not be cooled below 78° F or heated above 65°F during the period of day when the building is occupied. During the period of day when it is not occupied, no cooling is allowed but the building mcent home, hospice or other facility duly authorized exempts any "hospital and healthcare facility" anday be heated to 50°F. The regulation specifically tuberculosis hospital, clinic, nursing or convales defines these as "a building such as a hospital, to provide hospital or healthcare services under the laws of the jurisdiction in which the institution or facility is located." Doctors' offices are *not* specifically exempt under the regulations, unless the doctor has filled out a "Building Compliance Information Form" requesting exemption for his or her office before the August 9, 1979 deadline. Willful violation of the regulations carries a maximum penalty of $10,000 for each violation.

FAS Awareness Project gains impetus with SMS involvement. The State Medical Society's physician members are becoming increasingly involved in a statewide public information campaign to alert women on the potential dangers alcohol can have on their unborn babies. Further details appear in the SMS ORGANIZATIONAL section of this issue. ■

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When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

Coronary artery bypass surgery

THIS ISSUE OF THE *Wisconsin Medical Journal is* devoted to coronary disease. There are three papers on the subject.

One is a five-year follow-up study from the University of Wisconsin Hospital and Clinics on the results of coronary artery bypass surgery. Since this type of surgery is now being done more frequently than appendectomies in many institutions and there is a tremendous economic factor involved, the results of this survey are particularly interesting. This is especially true in view of the less favorable VA Cooperative Study that received such widespread publicity.

With the operative mortality rate down to zero in 1978 and the overall survival rate at five years of 93.4%, which equals the survival rate of the general population in the same age and sex groups, it appears that coronary artery bypass surgery does prolong life comfortably and the procedure is here to stay. It would also be interesting to learn how many of these patients have returned to work.—VSF

Reverse conservatism

THE SECOND IN THE series of obstetrical briefs is published in this issue. Written by Dr Stanley A Korducki of Milwaukee, it is entitled "Bleeding Late in Pregnancy."

In the last paragraph Doctor Korducki concludes that "it is obvious that the liberal and judicious usage of Cesarean section will do much toward decreasing maternal morbidity and fetal wastage." Improvements in anesthesia, surgical technique, and monitoring have made the procedure much safer. The decision to proceed with the Cesarean section early rather than as a last resort intervention has improved the statistics.

It is now considered more conservative to proceed with the Cesarean section in many instances than it was in the past. It wasn't long ago that two consultations were required prior to doing a Cesarean section, and the Joint Commission reviewed with jaundiced eye the percentage of Cesarean sections performed in a hospital.

What a fortunate, progressive turnabout of attitude this has been!—VSF

The team must have a captain

AS THE TEAM CONCEPT of patient care becomes more and more prevalent it brings with it its own peculiar deficiencies. Chief among them is loss of security on the part of the patient. As the responsibility for his care becomes divided among four or five specialists, he loses the confidence brought on by the knowledge that one trusted individual who knows his background and his illness well (and really cares) is in control. Sometimes key members of the team don't communicate with one another as often as the patient thinks they should. He sees treatment plans unilaterally altered without the referring physician's knowledge or approval. Prognostications rendered by the family physician are discounted by the specialist or vice versa. In this setting, when questions or complications arise, the patient often doesn't know which doctor to call. He may call the wrong one, or call several and receive conflicting advice. He begins to despair, and with justification.

Perhaps some of this can't be helped, but it can be devastating to the patient to be told by the surgeon that he thinks he removed all of the cancer at the time of the mastectomy and then be told by the consulting radiotherapist or oncologist at their first encounter that she has a very bad type of tumor and little hope of surviving five years.

Few hospital staffs can offer the luxury of multiple consultants in all specialties. As a consequence, physicians who seldom agree on anything and often even dislike one another are forced to play on the same team again and again.

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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It might be a good idea in such circumstances to establish ground rules which require that all pronouncements be cleared through or be made by the referring physician. That would force closer liaison among the physicians, better communications, and keep the inveterate crape hangers from spreading their gloom around. It might go a long way toward sparing the patient's feelings—not to mention those of the referring physician.—*WJB*

Toll-Free WATS line for members: 1-800-362-9080

As a service to its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference!

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Council acts on immunization

RECOGNIZING THE GROWING apathy among Wisconsin citizenry toward immunization, the Council, at its July 14 meeting, adopted the following resolution:

WHEREAS, There is continuing and growing evidence of a serious loss of immunization control over vaccine-preventable diseases in Wisconsin (especially mumps, measles, rubella, diphtheria and polio) requiring immediate remedial action, and

WHEREAS, The State Medical Society and its member physicians are strongly committed to the prevention of communicable diseases through both private and public efforts; therefore be it

Resolved, That the Council of the State Medical Society of Wisconsin:

1. support in every way possible the issuance by the Department of Health and Social Services of an emergency administrative rule to impose certain minimum immunization requirements for the admission of all school children (grades K-12) in the 1979-80 school term;

2. support the passage of legislation (AB 767) to become effective as rapidly as possible and certainly no later than the 1980-81 school year;

3. request its members to take steps to assure that all their patients have appropriate immunizations;

4. encourage all physicians to assess their patient care records to determine potential immunization deficiencies and to contact such patients, setting an appointment time for the immunizations and urging them to keep the appointment;

5. encourage all physicians to maintain patient immunization records;

6. direct the Society's Commission on Public Information, the Auxiliary, and staff to develop a statewide public information program to support the Immunization Action Program, and to enlist the support of government officials, media, employers and labor;

7. urge those associations and agencies responsible for the promulgation of immunization schedules to cooperate to establish a uniform schedule.

There is a legitimate sense of urgency here. According to the National Center for Disease Control, Wisconsin ranked among the highest states in the incidence of measles the past two years (5th two years ago, and 9th last year). Add to that the knowledge that Wisconsin was only one of four states reporting diphtheria and had its first cases of documented polio this year after a long respite, and it becomes apparent that corrective measures must be taken soon.

While Wisconsin's 1975 Immunization Checkpoint Law requires children entering school for the first time to be immunized against the childhood diseases, there remain many thousands of children already in school who haven't been immunized. In an attempt to catch up, the DHSS has prepared an emergency rule requiring basic immunization for students from kindergarten through grade 12 by the beginning of the 1979 school year. The rule will serve as an interim measure until passage of Assembly Bill 767*, and will remain in effect for 120 days. (See additional information in NEWS YOU CAN USE section of this issue.)

All physicians who treat children of school age must familiarize themselves with the rule. We would all do well to study the Council's Immunization Resolution carefully and give it our unqualified support. Family practitioners and pediatricians have an important public health role to play in childhood disease prevention, even if the public seems unenthusiastic. That role extends beyond diagnosis and treatment. It includes teaching and salesmanship. The time to begin is now! —WJB ■

---

*Assembly Bill 767 creates a conditional admission statute for all schools, nursery through high school. The school must admit a pupil who has not completed his immunization schedule, but only until the first school day in October. Penalties for failure to comply include suspension and fines. Requirements can be waived on grounds of religion or a medical excuse.

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand–name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

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Brain Death

The question of brain death—concepts and criteria

Phillip M Green, MD
Marshfield, Wisconsin

THE QUESTION of brain death is one of increasing concern to all medical doctors. It has to be separated from the determination of when should a patient be allowed to die. Prior to the technological developments which led to the capability of continuing to give support to someone who is no longer able to maintain cardiac or respiratory function, the question was not very important. In the common law there is strongly entrenched a cardiac definition of death. Thus, in *Thomas vs Anderson* (California, 1950),[1] death does not occur until the heart stops beating and respirations end. *Smith vs Smith* (Arkansas, 1958),[2] re estate of Schmidt[3] and other cases support and reiterate the cardiac and respiratory definition of death. The fact that physicians can recognize total and irreversible destruction of the brain on the basis of clinical and laboratory criteria and the need for such pronouncements has produced a need for further clarification of the status of statutory recognition of brain death. The additional technological advances resulting in the capability to transplant cadaver organs has resulted in an increasing need to recognize that destruction of the brain is the basis for death of the donor.[4]

There is a potential dilemma in the absence of legal recognition of the medically acceptable practice of pronouncing death on neurological criteria. Physicians who pronounce death on this basis may be disputed in a judicial proceeding with the contention that death occurs only when spontaneous respiration and heartbeat cease. This contention could be based on the common law definition of death which is generally held applicable to jurisdictions without specific statutes. Without statutory or case law recognition of the use of brain related criteria for pronouncing death, it is possible that a valid medical declaration of death could be considered illegal and lead to difficulty in the prosecution of a murder or civil liability on the part of a physician or hospital. Case law recognition of the legal validity of pronouncing death on brain related criteria, although helpful, is an inadequate solution to the dilemma that arises from the potential discrepancy between medically acceptable practice and legally acceptable practice for two important reasons. First, case law is fluid and subject to appeal and change by subsequent judicial action and second, court decisions to recognize the use of brain related criteria for pronouncing death may relate to certain special circumstances such as transplant organ donation.

The law does not initiate new concepts but once they are accepted seeks their proper integration into social codes as recognition of the concept of death as the result of the absence of brain activity. It is necessary for several reasons to develop legal acceptance of the concept of brain death: (1) The need for early removal of organs for transplantation. (2) The cost of prolonged use of extraordinary measures. (3) The prolongation of sorrow and grief of relatives. (4) The increasing awareness of the right to die with dignity.[5] The concept of cerebral or brain death as representing finite death has received support from a number of judicial decisions. These cases have related to the cause of death of individuals cerebrally dead

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as the result of criminal assault who subsequently have been organ donors. In 1971 a jury in Portland, Oregon, had to decide on the cause of death of a man comatose after a bullet wound. The patient had a flat electroencephalogram and was mechanically ventilated. His kidneys were removed for transplantation. Was it the removal of the kidneys or the missile injury that caused death? The jury considered the bullet wound to be the proximate cause of death and found the assailant guilty of second degree murder.[6] A year later a jury in Virginia heard evidence regarding a suit (*Tucker vs Lower*) against physicians for removing a heart while a donor who met the criteria of cerebral death was alleged to still be alive. The judge instructed the jury that they might use complete and irreversible loss of all function of the brain as a possible definition of death. The verdict was in favor of the defendants and presumably was based on the conclusion that death occurred when the brain ceased functioning and not when cardiac and respiratory activities stopped.[7] Two cases in California in which the defense rested upon the claim that the accused assailants had not killed their victims because the heart was beating when removed for transplantation were determined with initially contrasting results. In one case the judge instructed the jury to accept irreversible cessation of brain function as evidence of death. The accused was convicted of voluntary manslaughter. In the other case the judge upheld the traditional definition of death and dismissed the manslaughter charge, but the decision was later reversed.[6]

The need for a permanent statute also is indicated by the recent change in Massachusetts from the previous case of *Commonwealth vs Golston*[8] in which the use of brain death criteria was accepted, to the recent decision in the case of the *Superintendent of Belchertown State School vs Saikewicz*[9] in which the court stated, "We do not view the judicial resolution of this most difficult and awesome question—whether potentially life prolonging treatment should be withheld from a person incapable of making his own decisions—as constituting a gratuitous encroachment on the domain of medical expertise. Rather such questions of life and death seem to us to require the process of detached but passionate investigation and decisions that form the ideal in which the judicial process of government was created. We decline the invitation to formulate a comprehensive set of guidelines applicable generally to emergency situations involving incompetent persons. Such a wide ranging effort is better left to the legislative branch after appropriate study."[9]

The immediate reaction of physicians in Massachusetts was that this was an infringement on the right of medical practitioners. There have been sad and horrifying consequences of the Saikewicz decision in Massachusetts including the placement of a cardiac pacemaker in a brain dead woman and a terminally ill woman who was defibrillated 70 times in a 24-hour period before succumbing to her disease. Doctors are going to court to obtain permission not to treat brain-dead people. Confusion exists in Massachusetts concerning the exact meaning of Saikewicz, and this is resulting in confusion in medical and legal practice. There are two parts to the Saikewicz decision—one dealing with the substantive rights of competent and incompetent persons to decline life prolonging treatments and the other with the procedures to insure the rights of the incompetent person. The latter has caused the confusion. The court did say that we should not use extraordinary means of prolonging life or its semblance when it becomes apparent that there is no hope of recovery of the patient and implied that recovery should not be defined simply as the ability to remain alive. It should mean life without intolerable suffering. The court did, in addition, state that the ultimate decision making responsibility should not be shifted from the duly established courts of proper jurisdiction to any committee, panel or group ad hoc or permanent and regretted the approach of the New Jersey Supreme Court in the Quinlan case which entrusted the decision to the patient's guardians, family, attending physicians, and hospital ethics committee.[10]

Saikewicz does not deal with brain death except from a four-line footnote. However, this issue has been tied to the decision. Two of the first six so-called Saikewicz cases brought to the court have involved brain-death patients. The probate courts have sofar dismissed these cases. How has this confusion developed in the State of Massachusetts? How can it be prevented from occurring in other jurisdictions?

"Case law recognition of the legal validity of pronouncing death on brain related criteria, although helpful is an inadequate solution to the dilemma that arises from the potential discrepancy between medically acceptable practice and legally acceptable practice . . ."

A statute giving general recognition to this concept for all purposes would avoid inconsistencies under the law and would prevent repeated anguish produced in court cases. Such a law would allow a physician to terminate artificial respiratory support for a patient clearly dead by accepted and validated criteria. It would obviate the possibility that the physician, other health professionals, next of kin, guardians, and institutions might be held criminally or civilly liable for actions consistent with standards of current medical practice. A statutory definition of death would serve as a vehicle to translate a generally acceptable medical standard into a form that is accepted by most, if not all members of society. As such, it will help to minimize some of the burdens placed on the family and physicians of the dead person by facilitating honest relationships and communication between them in many ways. Until such policy recognition by legislation has occurred, the family confronted with the loss of a loved one who is dead by virtue of brain related criteria is frequently forced to deal with the confusing and misleading assumptions supported by an out of date common law that while the heart beats there is life and hope of recovery.

Kansas in 1970 was the first state to adopt such a brain-death statute. It read in part, "A person will be considered medically and legally dead if in the opinion of the physician there is absence of spontaneous respiratory and cardiac functions and attempts at resuscitation are considered hopeless, or a person will be considered medically and legally dead if in the opinion of a physician there is the absence of spontaneous brain function and it appears that further attempts at resuscitation will not succeed."[11] This statute provoked wide commentary in the medical and lay press, especially in its provision of two alternative definitions of death to be used at the discretion of the attending physician based on ordinary standards of medical practice. The legislatures of Maryland, 1972; Virginia, 1973; New Mexico, 1973; Alaska, 1974; and Oregon, 1975, have passed similar alternative definition laws since that time.

A second kind of brain death legislation appears to have been based on an article by Capron and Kass in 1972.[12] This article provided two general physiological standards. The authors proposed using an irreversible cessation of spontaneous respiratory and circulatory function, and in the event that artificial means of support preclude the determination that these functions, cardiac and respiratory, have ceased, irreversible cessation of brain function will be allowed. The determination in either case is again to be made by prevailing standards of medical practice. This formulation stipulates the conditions under which the brain-death criteria can be used instead of the traditional cardiac arrest criteria. Several states have subsequently passed legislation based on this concept—Michigan, 1975; West Virginia, 1975; Louisiana, 1976; Iowa, 1976; and Montana, 1977.

"A statutory definition of death would serve as a vehicle to translate a generally acceptable medical standard into a form that is accepted by most, if not all members of society."

A third kind of brain-death legislation is similar to the American Bar Association proposal in 1975 which states, "Whereas it is to the wellbeing of the public to cease all artificial life supports, respiratory and circulatory, after a human body is dead and whereas it is currently medically established that irreversible cessation of brain function is determination of death and whereas in the current technology of organ transplant it is vital that the donor's gift be in the best cellular condition, therefore, be it resolved that the American Bar Association offers the current definition of death as follows: For all legal purposes a human body with irreversible cessation of brain function according to the usual and customary standards of medical practice shall be considered dead."[13] The American Medical Association in December 1974, opposed the statutory definition of brain death.

Several legislatures have adopted statutes resembling the resolution of the American Bar Association including California, 1974; Illinois, 1975; Georgia, 1975; Tennessee, 1976; and Idaho, 1977. In California, for example, a person shall be pronounced dead if it is determined by the physician that the person has suffered total and irreversible cessation of brain function. There shall be independent confirmation of the death by another physician. In Illinois, death means for the purpose of the act the irreversible cessation of total brain function according to usual and customary standards of medical practice. In all, 19 states have passed brain death legislation by mid 1978. The statutes are pending in many other states. Whether by judicial or legislative means, brain criteria increasingly are widely used in the United States for the legal determination of death. A statutory approach seems to be the most widely used way of affirming death as brain death. By appropriate flexible wording, statutes can be established that recognize the concept of brain death as death without requiring costly and time-consuming judicial processes and still allow physicians to modify criteria as experience increases.

"We in Wisconsin can avoid the difficulties which seem to be developing in many of the 31 states that are dealing with the question on a judiciary level by accepting the Uniform Brain Death Act drafted by the National Conference of Commissioners on Uniform State Laws."

The Massachusetts court took 18 months to render its decision in Saikewicz. The importance of a good statute, however, cannot be underestimated as a bad law is worse than the situation of no law at all. The current climate of public mistrust of the medical profession has prompted some legislators to propose more complicated laws in an attempt to protect patients from erroneous or premature declarations of death.

The additional problem which is presented by the concept of cerebral death is the development of criteria which will be acceptable to persons holding various concepts of death, and this is where the difficulties concerning the accurate interpretation of death inevitably lead. When approaching the problem of evaluating criteria for determining death, it is worthwhile to keep in mind some formal characteristics that a set of procedures should fulfill. These criteria should be simple, clear and interpretable by a physician without the services of a consultant specialist, should give unequivocal results, be compatible with traditional methods of determining death, be comprehensible and acceptable to the general public, exclude reversible conditions that simulate death, and assess several functions to minimize the chance of error. The more comprehensive the criteria, the less likely will be the occurrence of alleged or actual errors in the final determination. The criteria should not undermine but should be compatible with the continued use of the traditional criteria (cessation of spontaneous heartbeat and respiration) in the vast majority of cases where artificial maintenance of vital functions has not been in use. The alternative criteria when they are used should determine the physician's actions in the same way as the traditional criteria, that is all individuals who fulfill either set of criteria should be declared dead by the physician as soon as he discerns that they have been fulfilled.[14] In other words, we add to the traditional legal concept of death. The criterion procedures should be easily communicable both to relatives and other laymen as well as to physicians. They should be acceptable by the medical profession as a basis for uniform practice so that a person determined to be dead in one clinic, hospital or jurisdiction would not be held to be alive in a different clinic, hospital, or jurisdiction. The criterion procedures should be acceptable as appropriate by the general public so as to provide the operational basis for handling the numerous social matters which depend upon whether a person is dead or alive and act to preserve the public trust in the ability of the medical profession to determine that death has occurred. The reasonableness and adequacy of the criterion procedures should be vindicated by experience in their use and by autopsy findings.

The original criteria proposed and all other acceptable criteria have to satisfy certain principles. They have to include prerequisites which the patient has to satisfy prior to being considered for the diagnosis of cerebral death and, in addition, include a statement of the basic tests which are necessary to establish a permanent cessation of cerebral function. The criteria should mention tests which are not ordinarily considered essential for the diagnosis of a dead brain but which will help confirm the impression. The fourth dimension which is necessary is the period of time that the above findings must be present to assure permanence.[5] The Harvard criteria established that cerebral function had to be absent and the patient had to be in a state of unresponsive coma. No spinal or brain reflexes were possible and apnea off the respirator had to be present. A flat electroencephalogram was necessary of at least ten minutes' duration, and all the tests had to be repeated in 24 hours. Hypothermia and central nervous system depressants had to be excluded.[15]

In 1974 the US Navy provided criteria which included that the etiology of the coma was presumptive of permanent damage to the brain. Depressant drugs and hypothermia were excluded and the coma must be observed for at least 13 hours. There had to be absence of cortical function and the patient had to be unresponsive to all externally applied stimuli except for simple spinal reflexes which could remain. Whenever possible the EEG would be used to confirm the absence of cortical function for 30-minute periods at least 12 hours apart. There had to be no evidence of brainstem function and pupils were fixed in midpoint or dilated positions and had to remain unresponsive to bright light. No demonstrable oculovestibular reflex was present and apnea had to be present for three minutes off the respirator on two occasions.[16]

In 1976 the Minnesota criteria were developed and accepted by the Minnesota Medical Association. These criteria required an irreparable intracranial lesion, absence of spontaneous movement, apnea off the respirator for four minutes, no evi-

dence of brainstem reflexes, midposition or dilated pupils, absent corneal, ciliospinal, Doll's eyes, gag, vestibular and tonic neck reflexes on the initial exam and on a subsequent exam at least 12 hours later. An electroencephalogram was confirmatory but not necessary in the Minnesota criteria.[17] It was felt that the EEG would provide objective documentation for medical, legal, and transplantation purposes and act in some cases to reassure the family that no electrical activity was present in the brain. Other jurisdictions including hospitals, counties, and states have proposed individual criteria, but the main features at this time include absent cerebral function, apnea, absent brainstem reflexes and the acceptance that spinal reflexes are not inconsistent with the presence of cerebral death. Most criteria also include the period of time that the above have to be present to assure permanence. The actual legal time of death is that time when the patient first satisfies the criteria.

The one decision in Wisconsin concerning brain death was delivered by Judge Pekowsky in September 1977, and involved a ward of the state who was found unresponsive. This decision accepted the standard of brain death as defined in other legal decisions. Judge Pekowsky allowed that the courts can and should modify common law when substantial societal and technological changes require,[18] thus supporting the concept of irreversible cessation of total brain function. While this established a judiciary precedent which is comforting at the present time, a statutory definition would assist in preventing the confusion which is currently present in the commonwealth of Massachusetts.

We in Wisconsin can avoid the difficulties which seem to be developing in many of the 31 states that are dealing with the question on a judiciary level by accepting the Uniform Brain Death Act drafted by the National Conference of Commissioners on Uniform State Laws. The measure which is being offered to state legislatures for enactment says, "For legal and medical purposes an individual who has sustained irreversible cessation of all functioning of the brain including the brainstem is dead. A determination of death under this section must be made in accordance with reasonable medical standards. The intent of this act is to supplement but not supplant traditional methods of determining death." Functioning is a critical word expressing purposeful activity in all parts of the brain as distinguished from random activity.[19] The legislative council referred Senate Bill 181 to the Wisconsin Committee on Human Resources.

On May 23, 1979, a public hearing was held on this bill and Dr Allan Levin of Madison represented the State Medical Society testifying in support of the passage of this bill which read, "For legal and medical purposes, an individual is dead when there is irreversible cessation of all functioning of the brain. Determination of death under this subsection shall be made in accordance with reasonable medical standards. Other usual and customary criteria may be used in determining death."[20] On June 21, 1979, Senator Opitz amended customary to medical so that the second sentence reads, "Other usual and medical criteria may be used in determining death." The American Medical Association which originally opposed statutory definitions of death in 1974 as of January 1979, proposed model state legislation to provide for a definition of brain death.

It is important at this time to accept the fact that a sound statutory definition is most necessary. Otherwise, various jurisdictions are liable to be subjected to changing definitions of death as the result of judicial decisions. It is not possible for standard and consistent medical care to be delivered in that climate.

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In Perspective

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

Herbicides and dioxin

According to a *Milwaukee Journal* news item[1] on June 22, 1979, the herbicide 2, 4, 5-T has again been implicated as a possible cause of birth defects, miscarriages, and stillborns. The article reports on a documentary by television station KRON in San Francisco done in the small northern California community of Orleans where 19 of 30 women in a three year period gave birth to deformed infants or terminated as stillborn. This alarming statistic followed the aerial spraying of surrounding forests with the herbicide 2, 4, 5-T.

Prior indictment of 2,4,5-T as a cause of spontaneous abortion has resulted from its use on the forests in the Alsea Basin area of Oregon. Based on the complaints of women in that area experiencing spontaneous abortions over a relatively short time interval, the Environmental Protection Agency (EPA) commissioned a study of the problem by the University of Miami Medical School and Colorado State University. The results of the study confirmed that the incidence of spontaneous abortion in the Alsea Basin was exceptionally high. A direct cause-effect relationship between 2,4,5-T and the miscarriages was not established, but the herbicide 2,4,5-T had been sprayed on the forests in that area by helicopters in large quantities. Based on the study, the EPA has temporarily halted the use of 2,4,5-T and Silvex, a related chemical, in forests and for clearing highway right-of-ways. The EPA ban on the use of 2,4,5-T and Silvex is incomplete, however, and the herbicides have not been banned for use in rice fields and on rangeland for grazing cattle where human exposure is alleged to be low.

The noxious agent is not 2,4,5-T or Silvex itself but dioxin, a highly toxic chemical which is always found to some degree in these herbicides as a contaminant. As a component of "Agent Orange," 2,4,5-T was widely used in Vietnam from 1961 to 1970 to defoliate the jungles.[2] In an article on June 17, 1979, the *Denver Post* reported that a Hanoi physician, Dr T T Tung, has noted an "explosion" of liver cancer in his country. In 1963 liver cancer was the eighth most common malignancy in Vietnam, but by 1979 Tung reported that liver cancer had moved to second place and was responsible for 10% of Vietnamese cancers. Doctor Tung is convinced of a relationship between the liver cancers and "Agent Orange," but a direct causal relationship has not been established.

Dioxin, the toxin in 2,4,5-T and Silvex, is known to cause liver abnormalities in both animals and humans. James Allen of the University of Wisconsin Medical School has found that 23 rats out of 60 (38%) developed tumors after being fed dioxin for 18 months. Allen has further demonstrated the extreme toxicity of dioxin by contaminating the food of rhesus monkeys in a concentration of 500 parts per trillion (.016 oz of dioxin to each 1000 tons of food.) Even at this relatively low concentration, five of the eight monkeys died of dioxin poisoning.[2]

When humans encounter dioxin on skin, it results in chloracne, an eruption of comedoes and yellow cysts. There are other harmful effects of dioxin ingestion by humans which are not well established. Some Vietnam veterans are reporting symptoms of paresthesias, depressions, decreased concentration, cancer and congenital anomalies in their offspring, even 8 to 12 years after their exposure. Dioxin is known to accumulate and persist in body fat. A reduction of body fat may well release dioxin into the blood stream and could possibly produce the late onset of symptoms. The Veterans Administration is attempting to investigate the extent of the dioxin exposure in the Vietnam veterans, but it is not authorized to seek out veterans who do not initiate treatment.

Assemblyman Tom Loftus (Sun Prairie) has introduced AB-245 to permanently ban the use of 2,4,5-T in the State of Wisconsin. The bill is due to be amended on the floor to include Silvex, the only other herbicide now in use containing dioxin. The Environmental Health Committee has unanimously endorsed AB-245 and urges its passage. The EPA ban on these herbicides is incomplete and may be temporary. Action at the state level is indicated to prevent exposure of the citizens of Wisconsin to dioxin contaminated chemicals.—Wendelin W Schaefer, MD, Chairman, Committee on Environmental Health

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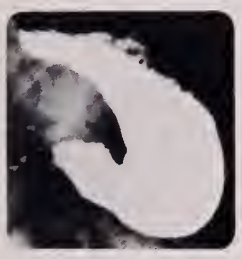

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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

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Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with. Autonomic neuropathy Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

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Scientific Medicine

REFER TO: Kahn DR, Rowe GG, Chopra PS, Hamann RC, Reynolds EW, Young WP, Kroncke GM, VanderArk CR, Dacumos Jr GC, Boake WC, Bittar N, and Bandow GT: Does coronary artery bypass surgery prolong life; results of a five-year followup study. *Wisconsin Med J* 78:23-26 (Aug) 1979

KEY WORDS: Coronary artery disease, bypass surgery, VA Cooperative Study

Does coronary artery bypass surgery prolong life?

Results of a five-year followup study

Donald R Kahn, MD; George G Rowe, MD; Paramjeet S Chopra, MD; Richard C Hamann, BS; Ernest W Reynolds, MD; William P Young, MD; George M Kroncke, MD; Condon R VanderArk, MD; G C Dacumos Jr, MD; William C Boake, MD; Neville Bittar, MD; and **George T Bandow, MD** Madison, Wisconsin

CORONARY ARTERY BYPASS surgery for coronary artery disease has been one of the most widely studied procedures in the history of medicine. It also has been one of the most controversial. Concerning the effects of bypass surgery in relieving angina, there has been almost uniform agreement that it is more effective than medical therapy.[1,2] Most investigators have shown a relief of angina in 90% of surgery patients versus relief in only 50-60% of medically treated angina patients.[3] Several investigators have demonstrated the physiologic benefits of bypass surgery.[4] When a blocked coronary artery is bypassed, the newly increased flow of blood supplied to the myocardium will increase function in ischemic myocardium but not in completely infarcted muscle.[5]

However, major controversy has surrounded the question of the effectiveness of coronary bypass surgery in prolonging life. While the majority of studies has indeed demonstrated a prolongation of life following surgical therapy as compared to medical therapy when both are matched with National Life Tables statistics,[6,7,8,9,10] one study[11] which showed no difference between surgical and medical mortality (excluding left mainstem disease) received tremendous publicity. This study, called the VA Cooperative Study, has been criticized for a number of reasons: (1) it examined only the best risk patients [those with chronic, stable angina] and excluded the bad ventricle group, (2) the followup time was short [two years], (3) there was a 17% cross-over from the medical to surgical treatment, (4) the overall surgical results were poor with higher surgical mortality and lower graft patency rate than many other surgical teams' figures during the same period, and (5) good surgical results are difficult to control when 13 different hospitals are contributing unequally to the total 286 surgical patients.

Hurst and associates[12] maintain that coronary bypass surgery is not controversial if the surgical mortality is below 2% since, in their studies, patients with left anterior descending or mainstem

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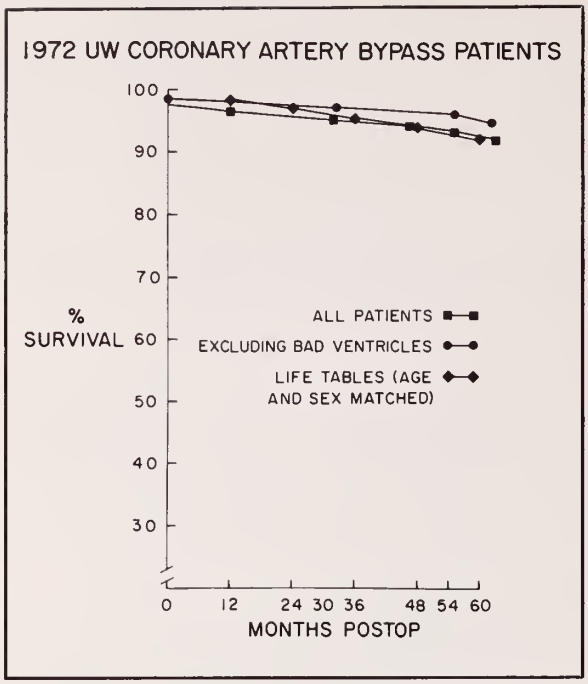

FIGURE 1—Comparison of coronary artery bypass patients at five years to National Life Tables statistics for age and sex.

disease, and two and three vessel disease could be returned to a normal life expectancy, at least for four or five years. With this thought in mind, we have reviewed our experience with 92 consecutive patients who underwent coronary artery bypass surgery during 1972 and compared their fate after five years to a group of people matched for age and sex who make up the "normal" life expectancy tables.

Patients and procedures. During 1972, 92 patients were operated upon at the University of Wisconsin Hospitals for coronary artery disease. There were 77 males and 15 females ranging in age from 37 to 67 years with a mean age of 57 years. Fifty percent of the patients had chronic stable angina, whereas the other 50% were either recent onset angina, stable angina that had become unstable, or outright preinfarction angina (16%). Fifty-eight percent had normal ventricles, 33% local areas of dysfunction, and 9% had generalized poor left ventricular function. All patients had preoperative cardiac catheterization and coronary arteriograms. The decision for operation was made together by cardiologist, cardiac surgeon, and the patient's personal physician. Operation was usually recommended when the patient had a major proximal occlusion (over 80%) in two or three coronary arteries, in the left mainstem coronary artery, in the left anterior descending coronary artery, and sometimes for an isolated right lesion if the right coronary artery was the major source of blood supply to the posterior left ventricle. The average number of bypass grafts per patient was 2.1 with up to four grafts in some patients. Twenty-three patients had endarterectomy of the right coronary artery and three patients had endarterectomy of the left anterior descending and circumflex coronary arteries in addition to the bypasses. Each patient received an average of 142 ml/minute of blood flow to the myocardium through the bypass grafts as measured by an electromagnetic flow meter at the time of operation.

Results. The overall survival rate at five years is 93.4%. The hospital mortality rate was 2.2%, and the late death rate 4.2%. This five-year survival rate after coronary bypass surgery is almost identical to the expected survival rate of the general population matched for age and sex according to the National Life Tables of 1972 produced by HEW (expected survival rate 92.7%) (Fig 1). If the eight patients are excluded who had the generalized extremely poor left ventricular function, our five-year survival rate is 96.4%, greater than that expected from the general population.

Discussion. This study shows that patients operated upon for coronary artery disease at our institution are returned to a normal life expectancy for at least five years. No study using medical therapy alone has come close to achieving this goal. In six different medically treated groups the five-year survival rate averaged about 70%.[13,14,15,16,17,18] Survival was considerably worse than the average if the patient had left mainstem disease, triple vessel disease or poor left ventricular function. Even in the VA study, despite a high operative mortality rate, incomplete revascularization, poor graft patency and some "cross-over" from the medical to the surgical group, surgical therapy was superior to medical therapy for left mainstem disease and triple vessel disease.

A wide variation in results after coronary bypass surgery from one hospital to another is not surprising. A number of factors are responsible for achieving success. For one, coronary artery surgery is a highly technical procedure involving anastomoses to vessels only one and two millimeters in diameter and even small technical errors can lead to graft failures. The more experienced the surgeon, the greater is his or her ability to obtain consistently good anastomoses. Arteriograms on postoperative patients should be performed in a surgeon's early professional years so as to be able to pick up defects in surgical technique. In addition the skill of the surgeon in protecting the myocardium during the operative procedure is extremely important and will determine the incidence of perioperative myocardial infarction,

and influence both the early and late results. Furthermore, surgical results are the tip of a pinnacle built upon clinical evaluation and cardiac catheterization data and are adversely affected by all errors made during these processes. Thus, if obstructions are not recognized they are not bypassed.

In a presentation of the natural history of coronary artery disease, Brusche[17] showed that the difference in the five-year survival rate between patients with mild angina and those with severe angina was only about 10% indicating that principal predictors of survival are the number of coronary arteries involved and the degree of left ventricular damage, not the severity of angina. From our own experience, we agree with these findings since many of our patients with severe life-threatening lesions have only mild angina. With the use of some of the newer noninvasive, diagnostic techniques such as exercise functional evaluation and exercise thallium myocardial wall motion studies and nuclear ejection fractions, 70-80% of dangerous proximal wall lesions can be diagnosed.[19,20]

However, can we accept the fact that there still remain 20% of patients at risk for sudden death because of severe proximal coronary artery obstructions? We feel not. Currently, the only way to accurately determine the number of vessels involved, the severity of involvement, and the precise site of involvement is to perform coronary arteriography. Therefore, it is our opinion that coronary arteriography should be performed on all physiologically young patients who have clinical manifestations of coronary artery disease without other serious life-threatening disease. Everyone is in agreement that operation for left mainstem disease is indicated. How can one be sure that mild angina is not caused by left mainstem disease? One of the authors performed a cardiac transplant on a 35-year-old patient who had had mild angina for six months, then occluded his left mainstem destroying his entire left ventricle with his first infarct. It seems like playing "Russian Roulette" with someone else's life not to know for sure how dangerous the obstructions are. The safety of cardiac catheterization and coronary arteriography, similar to cardiac surgery, depends upon the experience of the cardiologist and the team performing the study. In experienced hands, in a recent summary of 9,679 cases, the mortality rate was 0.16% and serious morbidity was 0.29%.[21]

We do not look upon treatment for coronary artery disease as either medical or surgical. After obtaining all the facts, including the coronary arteriograms, a decision is reached by the personal physician, cardiologist, and cardiac surgeon as to whether this patient needs operation at this stage of his disease. If medical therapy is decided upon, this does not mean that surgical therapy may not be necessary in the future. If surgical therapy is performed, the patient still needs medical therapy to help slow down the progression of the disease. This is the way medicine and surgery have worked together to treat other diseases in the past and is also the way that works best for the patient with coronary artery disease.

With refinements in technique, operative experience, and revolutionary improvements in myocardial protection during surgery, current coronary artery bypass surgery results show improvement even over the favorable results obtained in 1972. For instance, at our institution in 1977, 166 consecutive patients underwent coronary artery bypass surgery. An average of 3.4 grafts per patient were placed with some patients receiving as many as six grafts. This is compared to an average of 2.1 grafts per patient in 1972. Despite performing more grafts per patient currently, the hospital mortality rate is lower than in 1972. In 1978, 215 consecutive patients underwent coronary bypass surgery with one hospital death. Principally because of the VA cooperative study, general acceptance of the efficacy of coronary artery surgery in prolonging life is not high. Our experience and five-year followup studies indicate that a more positive attitude is warranted.

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Abstracts

A quantitative approach to determining disease response during therapy using multiple biologic markers. Application to carcinoma of the breast

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A mathematical model was developed to quantitatively evaluate tumor response utilizing multiple biological markers obtained during the treatment of patients with malignant disease. The biologic markers measured in patients with breast carcinoma were: three urinary polyamines (putrescine, spermidine, and spermine), three urinary nucleosides (pseudouridine; N^2,N^2dimethylguanosine; and 1-methylinosine), and plasma carcino-embryonic antigen (CEA). The distribution patterns of these markers were measured before treatment and five weeks after the initiation of chemotherapy in the patients. The clinical response of the patients was classified as stable or showing progression or regression. Ratios of the pretreatment and post-treatment levels of spermine/putrescine; spermine/spermidine; spermidine /putrescine; N^2,N^2-dimethylguanosine/pseudouridine; 1-methylinosine/pseudouridine; and 1-methylinosine / N^2,N^2-dimethylguanosine were also calculated. Pretreatment CEA levels were elevated in 76% of the patients, the three nucleosides in 35.5-37.1%, spermidine in 27%, spermine in 24%, putrescine in 6.5%, and the polyamine and nucleoside ratios in 10-20%. At least one marker abnormality was observed in 79% of the patients.

The distribution patterns of marker levels were generally consistent with differences in the clinical response of the patient to treatment. Levels of CEA, N^2,N^2-dimethylguanosine, spermine/spermidine, and spermidine/putrescine were significantly higher than normal and increased in proportion to the increase in the amount of disease. Nucleoside levels were generally in better agreement with disease response than the polyamines, but the polyamine ratios were better than the nucleoside ratios. CEA combined with nucleosides and polyamine ratios may monitor disease course more effectively than CEA combined with polyamines and/or nucleoside ratios. The correlations of N^2,N^2-dimethylguanosine/pseudouridine; N,$^2N^2$-dimethylguanosine; N^2,N^2-dimethylguanosine change with treatment/pseudouridine change with treatment; spermine change with treatment/spermidine change with treatment; N^2,N^2-dimethylguanosine change with treatment; 1-methylinosine change with treatment/N^2,N^2-dimethylguanosine change with treatment; 1-methylinosine, and 1-methylinosine/pseudouridine with disease status were significant.

A multiple regression equation using the 14 marker measurements and 12 ratios was developed to evaluate the treatment results; its multiple regression correlation coefficient ($R=0.891$) was about 2.4 times higher than the most sensitive single marker variable, N^2,N^2-dimethylguanosine/pseudouridine alone. Stepwise regression analysis showed that 15 was the minimum number of multiple marker measurements and ratios needed to achieve the maximum sensitivity for detecting metastases and monitoring the course of the disease during treatment. The regression equation showed reasonably good correlation between marker variables and the disease response of patients and characterized the nature of the therapeutic response fairly well, although the quantitative accuracy of the method is limited. ■

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Coronary arteriography after myocardial infarction

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● **Since the period early after myocardial infarction is one of high risk, 50 patients had coronary arteriograms done shortly after they were thought to have had myocardial infarction. Ninety-eight percent had coronary artery disease. Seventy-four percent showed evidence of left ventricular dysfunction on left ventriculography thought to be confirmation of myocardial infarction but the rest did not. One was found to have neither coronary disease nor infarction. Sixty percent were thought to have myocardium still at risk because severe disease was present in arteries which supplied good contractile myocardium. It was considered that 48% of these subjects might benefit from aortocoronary bypass grafts.**

Coronary arteriography after myocardial infarction supplies very useful and practical information concerning prognosis and therapy.

THE PROGNOSIS AFTER a myocardial infarction remains guarded since such subjects have an increased risk of reinfarction and/or sudden death.[1,2,3,4] Unfortunately retrospective studies have indicated that the history is unreliable in predicting sudden coronary death[3,5,6,7] since many historical features repeatedly described by relatives of those who have died suddenly are too nonspecific to be helpful.[5,6] Furthermore, although prodromata of myocardial infarction have been elicited from patients who are being treated for myocardial infarction,[8] prospective studies are much more difficult. Thus it has been concluded that the only therapy which has a chance of being effective in prevention of coronary death is the treatment of risk factors.[5]

Our hypothesis for this study was that myocardial infarction is a sufficiently dramatic event to bring the patient to medical care and to provide an occasion when coronary arteriography may justifiably be scheduled to determine the anatomy of the coronary lesions and the pattern of left ventricular contraction. This justification is based on three premises. First, extensive study has shown that the location and severity of coronary artery disease and the amount of left ventricular destruction are related strongly to prognosis.[9,10,11] Second, coronary bypass surgery is reported to prolong life in selected subjects with coronary disease.[12-17] Third, coronary arteriography is safe even though done shortly after myocardial infarction.[18,19] Consequently, we studied 50 patients with a history of recent myocardial infarction in whom coronary arteriograms were scheduled because of myocardial infarction rather than because of any symptoms before or after myocardial infarction. The present report details the results of this study.

Methods. Among 775 cardiac catheterizations there were 50 subjects in whom cardiac catheterization was scheduled solely because of a recent myocardial infarction. Between the time when the cardiac catheterization was scheduled and done, 10% developed angina pectoris but it is emphasized that this is not the reason why they were catheterized and that angina pectoris occurred after the decision to do catheterization had been made. In 32% of the patients there were minimal symptoms which were difficult to evaluate and may or may not have been related to the presence of coronary artery disease. Again these complaints were found incidentally by careful inquiry at the time the patient came into the hospital for a prescheduled cardiac catheterization.

The patient's hospital records, electrocardiograms, and the data supplied by referring physicians were reviewed for the basis on which the diagnosis of myocardial infarction was established. As is well known; it is not always possible to be certain whether myocardial infarction has occurred by clinical or any other currently accepted criteria. Nevertheless, in each case a cardiologist who had seen the patient in consultation accepted that myocardial infarction had occurred and arranged for the cardiac catheterization to be done.

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In all cases the cardiac catheterization was done by the Sones technique and the severity of lesions graded by increments of 25% reduction in cross section area as 25%, 50%, 75% on the thesis that in this range finer gradations are difficult to define in man. Any lesion producing 75% or greater obstruction was considered hemodynamically significant. More severe lesions are recorded but were not used to determine significance in this study since our experience indicates that these categories are less accurately defined.[20] Left ventriculograms done in the right and left obliques were studied for wall motion during normal and post-extrasystolically potentiated beats. In our laboratory we inject contrast material rapidly enough that ventricular premature beats almost invariably occur. Evaluation of left ventricular function included search for delay in contraction, incomplete contraction, and early systolic ventricular relaxation as well as identification of scars which thinned or deformed the myocardium. If ventricular dysfunction was present, the angiogram was repeated after nitrites to see whether myocardial contraction improved. From the composite of these observations an overall opinion of left ventricular function was crystallized. It was decided that no significant myocardium was at risk if most or all of the section supplied by a totally occluded vessel was infarcted, and the rest of the myocardium was supplied by vessels which were not significantly diseased. A large section of myocardium which appeared to contract well but which was supplied by a significantly diseased artery or arteries was considered potentially at risk of infarction. Such a decision clearly requires judgment and was made by two physicians who examined the film together and came to an agreement in each case.

Standard hemodynamic parameters of right and left-sided pressures cardiac output, work, and vascular resistance were compared in those with and without symptoms, but no significant differences were found.

Results. The average age of these individuals was 47.3 ± 9.4 years. There were five females and 45 males. Three of the five females, aged 45, 30 and 26 years, were receiving oral contraceptive medication at the time of infarction. Six subjects had two myocardial infarctions and were scheduled for catheterization in propinquity to the second infarct. The rest were believed to have had one. Twenty-nine, or 58%, were asymptomatic. Sixteen (32%) had minimal symptoms which were difficult to interpret and may not have been related to coronary artery disease. Five (10%) were thought to have developed angina pectoris in the interim between the infarction and the scheduled catheterization. Most of the procedures were done within six weeks of the time of myocardial infarction, and many patients had been inactive so they might have had more symptoms had they taxed their cardiovascular system more severely.

Coronary artery disease was present in 49 patients (98%) of the subjects in this study (Table 1). In one subject neither evidence of coronary artery disease nor destruction of the left ventricle was seen so it was concluded that the diagnosis of infarction may have been erroneous. In 12 individuals (24%) significant coronary artery disease was present which in five involved one vessel and the rest at least two vessels, but we found no evidence of left ventricular dysfunction. It is not believed that myocardial infarction is excluded in these individuals but that either it did not involve the left ventricle or the section of myocardium destroyed was too small to be seen by the rather gross method of left ventriculography. Thirty-seven, or 74%, had evidence of left ventricular infarction and coronary artery disease. Seventeen of these were believed to have destroyed all of the myocardium which was at risk from the

Table 1—Data base for study

775 Catheterizations Searched

50 (6.5%) catheterized only because of infarct.
49 (98%) had coronary artery disease.
37 (74%) showed evidence of infarct on left ventricular angiogram.
13 (26%) showed no evidence of infarction on angiogram.
30 (60%) thought to have left ventricular myocardium still at risk.
20 (40%) thought not to have more left ventricular myocardium at risk.
1 (2%) no evidence of infarction or coronary disease.

Table 2—Subjects without more myocardium at risk

Infarction present on ventriculography	17 (85%)
Completely occluded single vessel	12 (60%)
Significant nonocclusive lesion with distal myocardium destroyed	4 (25%)
Coronary artery 50% obstructed but large infarct	1 (5%)
Coronary disease present in vessels other than primary lesion	13 (65%)
No infarct seen on ventriculography	3 (15%)
Normal patient	1 (5%)
Occluded small right coronary artery	2 (10%)

Table = 20 patients

coronary artery lesions demonstrated (Table 2). Of these, 12 had a completely occluded vessel, and four had 75% or greater obstruction of a coronary artery but no complete occlusion. In one young woman there was a 50% obstruction of the left anterior descending coronary artery and a large antero-septal infarct. It was presumed that she had recanalized the artery. In addition, 11 of these 17 subjects had other lesions which would not ordinarily be thought to be significant enough to produce ischemia.

Among the 30 subjects who were thought to have myocardium at risk, as judged by coronary arteriography (Table 3), 14 had a completely occluded coronary artery and of these 11 had at least one additional lesion of 75% or greater severity and seven had severe three-vessel disease. Sixteen had a lesion producing 75% or more occlusion of a coronary artery as their worst lesion but had no complete occlusion. By the process of selection there were no subjects in this group who had less than 75% occlusion of a coronary artery. Twenty of these subjects had lesions elsewhere which produced less than 75% obstruction.

Among the 29 subjects who had no symptoms at the time of coronary arteriography, 15, or 52%, had complete occlusion of one coronary artery and of these seven had additional lesions which were equal to or greater than 75% obstruction (Table 4). Twelve had 75% or greater obstruction of a coronary artery as their worst lesion and only two had lesions of less than 75% obstruction as their worst lesion. Eighteen of these subjects in addition to their worst obstructions had lesions which did not produce 75% obstruction. It was thought that 16, or 55%, of these subjects still had myocardium at risk of infarction but that 13 had completed their infarction and probably did not have muscle currently at risk. Two were believed to be essentially normal since the coronary lesions found were not of sufficient severity to constitute a present risk.

Table 3—Subjects with more myocardium at risk

Evidence of infarct on angiogram	20 = 67%
No evidence of infarct on angiogram	10 = 33%
Complete occlusion of a coronary artery	14 = 47%
75% or greater but incomplete occlusion	16 = 53%
Additional lesions producing <75% occlusion	20 = 67%
Total	30 patients = 60% of series

Table 4—Symptoms versus no symptoms

	No Symptoms	*Symptoms*
Complete occlusion 1 coronary artery	15 (52%)	11 (52%)
Complete occlusion + 75% obstruction	7 (24%)	5 (24%)
75% or more obstruction worst lesion (no complete occlusion)	12 (41%)	10 (48%)
90% or more obstruction but no complete obstruction	12 (41%)	14 (67%)
Additional lesions in other vessels	18 (62%)	15 (71%)
More myocardium at risk	16 (55%)	14 (67%)
No myocardium at risk	13 (45%)	7 (33%)
Total	29 patients	21 patients

Twenty-one patients had symptoms which could have been cardiovascular in origin and in some of these symptoms were probably angina. Eleven, or 52%, of these had complete occlusion of a coronary artery and five of these had additional lesions of 75% or greater obstruction of a coronary artery. There were no individuals who had less than 75% obstruction of a coronary artery as their worst lesion. Fifteen had additional lesions producing less than 75% stenosis. It was believed that 14, or 67%, of these subjects had myocardium still at risk of being infarcted because of the severity of the lesions in its nutrient artery and in 7, or 33%, it was thought that there was no additional myocardium at risk.

Among the five patients thought to have angina, three had complete occlusion of a coronary artery and one had an additional 75% obstruction of a coronary artery. There were two without complete coronary occlusion in whom lesions of 75% or greater were the worst obstruction, hence all these individuals had significant disease in a coronary artery. In addition, three of these five had nonsignificant lesions scattered in the coronary arteries. Thus four of these patients with angina were thought to have additional myocardium at risk of infarction while one did not.

All of the data which have been discussed to this point are based on the presumption that 75% reduction in area (50% decrease in diameter) is a significant coronary lesion. Although we recognize that we have difficulty in measuring more significant lesions accurately,[20] since more severe lesions are described routinely, 90% or greater obstruction was tabulated also. Of the 30 subjects with muscle at risk, 22, or 73%, had 90% or greater obstruction of a major coronary artery. Furthermore, one subject had 75% obstruction of the left main coronary artery. Thus severe lesions were present in many of these patients. Symptoms did not help identify those with 90% obstruction.

Discussion. Recent data from multiple sources indicate that myocardial revascularization may

significantly influence mortality from coronary artery disease.[12-17] Furthermore, careful studies of the coronary anatomy have established that prognosis is related to the severity of coronary artery disease and to left ventricular function.[9,10,11] Thus Bruschke and associates found groups with excellent life expectancy when there was minimal coronary disease and the left ventricle was normal, but markedly increased mortality in those with severe coronary artery disease and left ventricular dysfunction.[10] Since this is the case and since the interval immediately post myocardial infarction is a period of high risk from coronary artery disease,[1-4] it seems logical to study patients after infarction to determine the anatomy of the coronary circulation and to see what myocardium is left at risk. When these data were discussed with the present group of patients, they agreed to coronary arteriography in order to help establish their prognosis.

Bertrand, *et al* concluded from their study of 76 patients with acute myocardial infarction that 54% had lesions which could be ameliorated by surgery and that these subjects needed to be protected against further myocardial infarction.[18] The conclusion of the present study is similar. Thus two individuals could be reassured that nothing significant was found and that their prognosis was excellent. One additional individual was found to be completely normal. In 17 subjects the view was expressed that the infarction had destroyed as much muscle as there was at risk and that no treatment was needed other than that aimed at preventing extension of atherosclerosis. By contrast, coronary lesions of significant severity were found in arteries supplying good distal myocardium in 30, or 60%, of these patients.

There are other ways of treating coronary artery disease than by myocardial revascularization,[21,22,23] and it is currently debated whether surgical or medical therapy is preferable.[24-27] It seems probable that surgical treatment is preferable in some patients and medical treatment is better in others, but it is doubted that this decision can be made intelligently without knowing the anatomy of the coronary lesions since some varieties of disease carry much greater and more immediate risk than others.[9,10] A vast amount of physiological data reviewed recently indicates that the principles of revascularization are sound.[28] Much data[12,16] including several prospective and/or randomized studies[13,14,15,17] show better survival and symptom relief and support the clinical value of myocardial revascularization, and there is abundant evidence that patients receiving traditional therapy for coronary artery disease in the phase immediately after a myocardial infarction frequently have a poor prognosis.[1-4] Clearly more data are desirable but in the interim while data is being collected, physicians and patients will continue to have to reach decisions in the absence of a final or universal opinion. Indeed we must consider the possibility that no concensus will ever be reached since physicians and surgeons, as well as medical and surgical therapy, continue to evolve. What is current today may remain of dubious value for many years and by then more changes will further complicate decision-making. In the opinion of the present authors the only position which cannot be justified now is the view that time-honored treatment should be continued until the present controversy is resolved.

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KEY WORDS: Coronary artery disease, myocardial infarction, atherosclerosis, coronary arteriography

Significant coronary artery disease in the postmyocardial infarction patient

Lowell F Peterson, MD, Appleton, Wisconsin

● **The first clinical manifestation of coronary artery disease is often acute myocardial infarction. The subsequent mortality rate for patients who survive this first myocardial infarction is higher than for the general population, and the prognosis is closely related to the coronary anatomy and left ventricular function. Identification of significant coronary disease early postmyocardial infarction may lead to more appropriate therapeutic decisions and prognosis determination. This study evaluates the coronary pathologic anatomy in patients studied early, intermediate, or late postmyocardial infarction.**

IN 1972 Dr F Mason Sones, Jr stated: "Ideally, coronary arteriography and left ventriculography should be an essential part of routine diagnostic study of any patient suspected of having coronary atherosclerosis." He further stated: "If acute myocardial infarction occurs as the first clinically recognizable event in the patient's history, coronary arteriography should be performed as soon as the myocardial injury has healed and the patient's functional status has stabilized."[1]

From the Department of Medicine and Cardiology, Appleton Memorial Hospital, Appleton, Wisconsin. Publication support provided. Reprint requests to: Lowell F Peterson, MD, 900 East Grant St, Appleton, Wis 54911. (Phone: 414/739-3171). Copyright 1979 by the State Medical Society of Wisconsin.

Statistically, the survivor of a myocardial infarction faces a marked increase in risk of left ventricular failure, sudden death, recurrence of myocardial infarction, and overall mortality. The ultimate prognosis appears to be more closely related to the coronary anatomy and left ventricular function than to the symptomatic manifestation of the disease.[2,3,4]

Identification of significant coronary artery disease early postmyocardial infarction may lead to more appropriate therapeutic decisions as well as more accurate prognostic information.

This study defines the coronary artery disease present in three subgroups of patients studied by coronary arteriography early, intermediate, or late postmyocardial infarction.

Method. The patient population is defined in Table 1.

Two of three of the following criteria were necessary for the diagnosis of previous myocardial infarction: (1) a documented history or enzyme evidence of myocardial infarction, (2) electrocardiographic Q-wave evidence of myocardial infarction, and (3) coronary occlusion and compatible left ventricular dysfunction by angiography.

The criteria for significant disease was defined as a 70% or greater stenosis of the left anterior

CORONARY ARTERIOGRAPHY/continued

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Table 1—The population subgroups. The total coronary arteriography population was 733 patients of which 360 (49%) had previous myocardial infarction

Subgroup I: 217 Patients (60%)
Catheterization study 1-3 months postmyocardial infarction

Subgroup II: 47 Patients (13%)
Catheterization study 4-12 months postmyocardial infarction

Subgroup III: 96 Patients (27%)
Catheterization study greater than 12 months postmyocardial infarction

Table 2—Age and sex distribution of subgroups and area of previous myocardial infarction.

		Subgroup		
		I	II	III
Sex	M	197 (90.8%)	41 (87.2%)	87 (90.6%)
	F	20 (9.2%)	6 (12.8%)	9 (9.4%)
Average Age	M	51 (28-69)	53 (37-74)	54 (35-73)
	F	54 (35-64)	53 (49-59)	58 (52-64)
	Combined	52	53	54
Area %	I	44.7	46.8	49.5
	P	2.8	8.5	5.2
	I/P	3.7	0	2.1
Total		51.2	55.3	56.8
	A	44.2	38.3	36.0
	I/A	4.6	6.4	7.2
Total		48.8	44.7	43.2

M—Male, F—Female
I—Inferior, P—Posterior, A—Anterior

Table 3—The reason for study (A), number of coronary vessels with significant disease other than the vessel causing the myocardial infarction (B) and disposition (C) of each subgroup given in percentage. The "routine" study case was without clinical angina. The 3 and 4-vessel disease patients had subtotal occlusion of a vessel and/or main left disease.

		Subgroup		
		I	II	III
A.	Angina	35.9	66.0	87.5
	Routine	62.7	25.5	5.2
	Other	1.4	8.5	7.3
B.	0	19.8	23.4	9.4
	1	29.1	29.8	30.2
	2	38.7	34.0	40.6
	3	11.5	12.8	15.6
	4	0.9	0	4.2
C.	Active	23.1	12.8	6.2
	Limited	45.6	48.9	39.6
	Surgery	31.3	38.3	54.2

descending, circumflex, and right coronary arteries, or a 50% or greater stenosis of the main left coronary artery. If the vessel causing the infarction was not totally occluded, and if minimal loss of ventricular wall motion was noted, the vessel was considered as "cause of the myocardial infarction" and also as "significant disease."

The disposition of the patient was defined as: (1) *active*—no restrictions or cardiac medications, (2) *limited*—reduced activity and/or drug therapy, or (3) *surgery*—coronary revascularization.

Results. The sex ratio is similar in each subgroup (Table 2).

The age range for males is similar in subgroups 2 and 3. Subgroup 1 includes a younger age group but the overall average age for the three subgroups is quite similar. The age range was 45 to 65 in 84% of the total patients (Table 2).

The area of previous myocardial infarction favors the inferior-posterior wall over the anterior wall in all three subgroups with the difference being 10.6% in subgroup 2, 14.6% in subgroup 3, but only 2.4% in subgroup 1. This may be due to poorer prognosis of anterior myocardial infarction patients or to the increased number of coronary branches on the inferior and posterior wall (Table 2).

Angina was the primary indication for cardiac catheterization in two-thirds and seven-eighths of subgroups 2 and 3 respectively. In subgroup 1, however, the recent myocardial infarction was the primary indication for catheterization in 62.7% with angina coincidentally present in 35.9% (Table 3-A).

In spite of the temporal differences at which the three subgroups were studied, a striking similarity is noted in the presence of significant 1, 2, and 3 vessel coronary artery disease present postmyocardial infarction (Table 3-B).

Angina was absent in almost two-thirds of subgroup 1, but only 23% of these patients could be returned to full activity. The 46% of subgroup 1 patients who received limited activity recommendations did so with the indications for follow-up clearly defined. The percentage of patients in subgroups 2 and 3 referred for myocardial revascularization and those allowed full activity was clearly different than in subgroup 1 (Table 3-C).

The data for subgroup 1 patients *without* angina is tabulated (Table 4). The 31 patients (22.8%) of subgroup 1 without angina who were referred for surgical revascularization included 15 patients with three-vessel significant coronary artery disease.

Discussion. Many studies have shown the prognostic implications in survivors of myocardial infarction. Oberman, Jones et al[5] showed that patients with previous myocardial infarction, angina, and a vessel stenosed more than 50%, followed 22 months, had a mortality rate of 12.5% for single vessel disease, 37% for two-vessel disease, and 39% for three-vessel disease, whereas the risk in patients without previous myocardial infarctions was 0%, 19%, and 19% respectively. Webster et al,[6] in a six-year followup study, found a 20%, 42%, and 80% mortality rate for one, two, and three-vessel high grade proximal disease postmyocardial infarction, and 17.2%, 37%, and 50.6% for patients without previous myocardial infarction. Bruschke et al[2] found that with a single vessel occluded and additional moderate lesions there was a 38% five-year mortality rate and that patients with a total right coronary artery obstruction and a subtotal left anterior descending coronary lesion had a 74% five-year mortality rate. They also reported a 42.6% five-year mortality rate in those patients with one previous myocardial infarction and a 49% mortality rate if there had been more than one myocardial infarction. This was compared to a 20% mortality rate in patients with no previous myocardial infarction.[7]

The presence of angina postmyocardial infarction is not the same as myocardial infarction without subsequent angina from a prognostic point of view. The three subgroups in this study differ in respect to angina, but do not differ significantly in respect to anatomy. It is presumed that some high risk patients not studied early died before reaching one year postmyocardial infarction. Moss et al[8] found postmyocardial infarction death was highest in the first six months posthospital discharge (6%), with 59% of these patients dying within two months and 76% dying within three months posthospitalization.

In spite of these impressive statistics, patients are frequently returned to full activity postmyocardial infarction without foreknowledge of the pathologic changes in the coronary circulation. The coronary pathologic anatomy by itself is a prognostic risk factor which should be evaluated in the early postmyocardial infarction period.

The patient who has had a previous myocardial infarction and has significant coronary artery disease with or without angina pectoris may present a therapeutic dilemma in the era of coronary revascularization surgery. The results of the recent VA Cooperative Study[9] and a report by Rosati[10] are at odds with reported surgical series results based on life table analysis.[11,12,13] If it is subsequently determined that aorto-coronary bypass surgery prolongs life and prevents sudden death in postmyocardial infarction patients with significant coronary artery disease, the wide-

Table 4—*Subgroup I patients without angina.* Three additional patients had two occluded vessels and additional disease.
Disposition: Limited—65, Active—40, Surgery—31.

Previous MI	Significant Anatomic Disease Postmyocardial Infarction													
		1-Vessel				2-Vessel					3-Vessel			
Vessel	O-Vessels	RCA	CCA	LAD		RCA/LAD	CCA/LAD	CCA/RCA	LAD/MLCA		RCA/CCA/LAD	CCA/LAD/MLCA		Totals
RCA	16	10	5	8		2	16	3	1		5	2		68
CCA	4	1	2	0		4	2	1	0		1	0		15
LAD	11	3	6	8		5	8	3	1		4	1		50
		14	13	16		11	26	7	2		10	3		
	31	43				46					13			133

Legends —
MI — Myocardial infarction
RCA — Right coronary artery
CCA — Circumflex coronary artery
LAD — Left anterior descending coronary
MLCA — Main left coronary artery

spread early use of coronary arteriography in this population would be justified. There is diversity of opinion regarding diagnostic studies of these patients at the present time.[14,15,16,17]

The aggressive approach to coronary arteriography in the postmyocardial infarction patient is based on the assumption that substantial and significant coronary atherosclerosis may be present in patients who remain asymptomatic. If the pathologic coronary anatomy is significant early postmyocardial infarction and if a significant number of deaths occur in the first three months posthospitalization for myocardial infarction, there may be no merit in awaiting the onset of symptomatology. Early coronary arteriography postmyocardial infarction hopefully will lead to more appropriate therapeutic decisions and prognostic accuracy.

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Abstracts

Congenital ocular motor apraxia; a possible disconnection syndrome

WILLIAM W ORRISON, MD and WILLIAM C ROBERTSON JR, MD, Madison, Wis: *Arch Neurol* 36:29-31 (Jan) 1979

In 1952, Cogan introduced the term "congenital ocular motor apraxia" (COA) to describe an abnormality of eye movements characterized by absent or defective voluntary horizontal gaze. Since his original description, there have been few subsequent reports of this disorder. A ten-year review of clinical records from the University of Wisconsin Hospitals disclosed eight patients with COA. In two patients subjected to neuroradiologic testing, agenesis of the corpus callosum was detected. Voluntary horizontal gaze appears to be a learned phenomenon, and defective interhemispheric transfer of visual information may be important in the pathogenesis of COA. ■

Effect of prednisone on growth and bone mineral content in childhood glomerular disease

RUSSELL W CHESNEY, MD; RICHARD B MAZESS, PHD; PHILIP ROSE, and DIANE K JAX, RT (University of Wisconsin Medical School, Madison, Wis): *Am J Dis Child* 132:768-772, 1978

Children with acquired glomerular disorders were divided into two groups: group 1 patients received short-term daily or long-term alternate-day prednisone (up to 2.7 mg/kg/48 h); group 2 patients received no corticosteroids. Height, bone mineral content (BMC) and the density of bone were evaluated in the two groups and compared to over 800 age- and sex-matched controls using the technique of photon absorption.

Significant demineralization was present in 18 of 25 steroid-treated and none of 17 nonprednisone-treated children ($p<0.001$). Group 1 patients were approximately 5% shorter than control, whereas group 2 patients were only 2% shorter ($p<0.02$). Height velocity, measured for at least 12 months, was 2.6 ± 0.8 (SD) cm/yr in group 1 and 5.1 ± 0.8 cm/yr in group 2 patients ($p<0.05$). When prednisone therapy was stopped, six patients had an increase in height and BMC toward normal values.

This study suggests that BMC and height velocity are correlated in children with glomerular disease. Both appear to be influenced by alternate-day prednisone therapy. ■

ONE OF A SERIES
COORDINATED BY

Richard C Brown, MD
Eau Claire, Wisconsin

BLEEDING LATE IN PREGNANCY

Stanley A Korducki, MD
Milwaukee, Wisconsin

No matter what amount of experience in obstetrics a physician may have, a call from a patient bleeding late in pregnancy is always alarming. There is justification in this since this type of bleeding may result in fetal loss, and despite medical advances it still is one of the top three causes of maternal demise. For these reasons, it is necessary for anyone doing obstetrics to periodically review these problems.

While diagnosis of placenta praevia and abruption of the placenta immediately come to mind, it is realized that other causes of bleeding not of intrauterine etiology may be present. Cervical polyps, malignancies, and post-coital trauma represent but three nonuterine entities. Diagnosis of these can be made by cautious speculum examination. If manipulation of the cervix and lower uterine segment is avoided, there is little likelihood that severe bleeding will result from the examination. Certainly, if placenta praevia is strongly suspected, or if the degree of bleeding is active, the examination should be performed in the hospital. Once these extrauterine causes have been ruled out, attention must then be directed toward the possible diagnosis of abruptio or placenta praevia.

Placenta praevia has been reported as occurring in one half to one percent of pregnancies. Every physician, no matter what his field of practice, remembers that painless, bright red vaginal bleeding occurring late in pregnancy is suspicious of placenta praevia. However, as every practitioner of obstetrics knows, this bleeding may occur anytime after the twentieth week of pregnancy.

The diagnosis of placenta praevia in modern day practice can be made by ultrasonography with an accuracy approaching 95 percent. In the early stages of pregnancy, the placenta occupies a much lower position in the uterus. At this stage, the diagnosis of placenta praevia is often made albeit erroneously. As the pregnancy progresses, the placenta is seen to "migrate" toward a more normal fundal position. Many reported placenta praevias at six months will be found in a normal position at term. Therefore, it is necessary that serial ultrasound examinations are necessary for proper diagnosis.

Certainly not everyone has an expensive diagnostic ultrasound apparatus available. In the absence of this diagnostic tool, x-ray studies can be carried out. Soft tissue radiographs can be used with a high degree of accuracy. Even a single film can be of assistance. If nothing else, careful palpation of the abdomen to determine the relationship of the presenting part to the pelvic inlet can make the attending physician aware of the possibility of praevia.

Pelvic examination for the diagnosis of placenta praevia must not be done outside of the hospital environment. If it is to be performed, it should be done only in those cases where the severity of the bleeding makes an immediate diagnosis mandatory. The diagnosis of placenta praevia is not made by "poking a finger" into the placenta since this may result in immediate and severe hemorrhage. Even the most gentle intracervical palpation may cause life-threatening bleeding. Consequently, this examination must be done under a "double set up" so that immediate surgery may be performed. Many physicians are hesitant to call out a whole operating crew to perform a pelvic examination. However, the importance of that mother and that baby far outweighs any inconvenience to personnel and most certainly plays no role in cost containment.

Abruptio placenta is the premature separation of a normally implanted placenta. This condition usually occurs in the last ten weeks of pregnancy. Multiple etiologic factors have been cited in the

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Doctor Korducki is a member of the State Medical Society's Maternal Mortality Study Committee of the Commission on Maternal and Child Health. Reprint requests to: Stanley A Korducki, MD, 3201 South 16th St, Milwaukee, Wis 53215. Copyright 1979 by the State Medical Society of Wisconsin.

literature, but the frequent association with preeclampsia and hypertensive states is noteworthy.

The significance of this disease process lies in the fact that all reported studies indicate a fetal loss in excess of 50 percent. Even worse is the fact that maternal mortality can and does occur even with adequate therapy. Contributing to this is the development of an intravascular coagulopathy in severe cases.

Principles of management of severe bleeding complications of late pregnancy should be aimed at prevention of maternal shock, hypovolemia, and the resulting hypoxemia. Disseminated intravascular coagulopathies must be considered especially in cases of abruption, and proper laboratory studies to determine the presence or absence of this complication should be carried out. The use of blood transfusions and intravenous fluids promptly and in adequate amounts is necessary to obtain satisfactory maternal and fetal outcomes.

On admitting a bleeding patient to the hospital an adequate intravenous line should be immediately opened before any examinations are carried out. Second, adequate amounts of blood must be available and must be crossmatched. Thirdly, a diagnosis of the cause of bleeding must be made. Finally, a definitive therapeutic decision should be reached and carried out.

Modern day obstetrical practices are not within the scope of this presentation. Nevertheless, it is obvious that the liberal and judicious use of Cesarean section will do much toward decreasing maternal morbidity and fetal wastage. Prompt attention and action by attending personnel is the foundation for the successful management of bleeding late in pregnancy. ■

Book Review

Carcinogenesis—A comprehensive survey, volume 4
Nitrofurans: Chemistry, metabolism, mutagenesis, and carcinogenesis

GEORGE T BRYAN, MD, PhD, Editor (Wisconsin Clinical Cancer Center, Madison, Wis). Raven Press, New York, 1978, pp 238

Nitrofurans—the fourth volume in a series of books entitled *Carcinogenesis—A Comprehensive Survey* summarizes and reviews information about the 5-nitrofurans relevant to understanding their genotoxic and oncogenic effects.

During the last ten years evidence that 5-nitrofurans are mutagenic and carcinogenic has caused concern about the level of human exposure and the potential for adverse health effects. These compounds have been used around the world as human and veterinary medicinals and food additives. They do not occur in nature but are synthesized. Several compounds have been used to treat or prevent bacterial infections in humans and animals. Some have also demonstrated antifungal activity. They have been used as food preservatives and as veterinary feed additives.

Direct exposure may occur during manufacture, packaging, distribution, sale, or application of the materials. Indirect exposure can occur by ingestion of milk or meat products obtained from treated animals. As yet no human neoplasm has been attributed to such exposures. The materials have been shown to damage DNA. The chemistry of their synthesis, biotransformation, and excretion is discussed.

Some nitrofurans have anticancer activity and have been used to treat testicular cancers. Nitrofurans enhance damage caused by physical agents such as heat or radiation. Their interactions with damage to macromolecules by other chemicals and drugs may also be useful.

Common toxic reactions to these drugs involve the gastrointestinal system, skin, lungs, liver, and may cause nausea, vomiting, diarrhea, abdominal pain, bleeding, headache, fatigue, facial flushing, thirst, dyspnea, anemia, eosinophilia, and peripheral polyneuropathy.

Oncologists, chemists, environmental scientists, toxicologists, pharmacologists, public health scientists, ecologists, and regulatory officials should find this survey of the nitrofurans of interest.

DOROTHY J BUCHANAN-DAVIDSON, PhD
Science Writer, WCCC ■

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Organizational SMS

SMS testifies on medical liability bills

"There is a danger in creating a 'witness for hire' or person who spends more time in a plane and a court room than in the practice of medicine," Fred Kriss, MD, Madison, told members of the Assembly Judiciary Committee July 17.

Doctor Kriss was testifying on behalf of the State Medical Society at a hearing concerning several medical liability bills, including Assembly Bill 637 which would require that any witness in a malpractice action be licensed and practicing in Wisconsin and must provide that he or she has satisfactory experience and training in the medical issue at hand.

While SMS supports the bill, Doctor Kriss stated that the bill's requirement that a witness be from Wisconsin or a contiguous state is secondary to assuring the expertise and qualifications of the medical witness.

Testifying on other medical liability bills, Doctor Kriss:

- Said that binding arbitration, as provided under AB 638, would provide the consumer with another option to utilize in malpractice actions, would ease the panel backlog and at the same time serve to resolve costly and lengthy malpractice actions.

- Objected to AB 654 which would allow attorneys to consider all future medical expenses in determining their contingency fees. "Juries do not take into consideration attorneys' fees when estimating future medical expenses," Doctor Kriss stated. "Awards for future medical expenses belong to patients for their future care," he said.

- Opposed AB 655 which would render formal Patient Compensation Panel findings inadmissible in court. Doctor Kriss reminded the Assembly Committee that legislators, attorneys, and physicians agreed when they were drafting the guidelines for the patient compensation system in 1975, that formal panel findings should be admissible in a court of law.

Visiting nurses arrive at SMS

The Visiting Nurse Service moved its headquarters last week into the State Medical Society building at 330 East Lakeside Street in Madison.

The 70-year-old agency is a private, nonprofit agency which provides home healthcare and mobile meals to anyone in Madison, Monona, Shorewood Hills, and Maple Bluff.

The staff of professional nurses, homemaker/home health aides, physical therapists, occupational therapists, social workers, and more than 250 volunteers are dedicated to seeing that people who need healthcare services can receive it in their homes.

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1979

3	Dane County Medical Society Board of Trustees
9	Dane County Medical Society HMP Committee
9	EPSDT Technical Advisory Committee
11	WisPRO Medical Care Evaluation Committee
11	WRF Board of Directors
11	Ad Hoc Committee on Women's Health Issues
11	Meeting with Pharmacy Examining Board
12	WisPRO South Central District Review Council
12	WisPRO Ancillary Services Review Committee
13	SMS Services, Inc
14	Finance Committee of SMS Council
14	SMS Council
18	WisPRO Executive Committee and Board of Control
19	Subcommittee on Accreditation
23	Wisconsin Academy of Physicians Assistants
24	Wisconsin Academy of Physicians Assistants
27	SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis. ■

Jail Health Program receives fourth year funding

Doctor, does your county jail currently participate in the Jail Health Care Project of the State Medical Society of Wisconsin and the American Medical Association? Would you consider participating in the program by delivering medical care to local jail inmates? If your answer is "yes," the following information may be of particular interest.

The State Medical Society recently was awarded funding from the Law Enforcement Assistance Administration to carry out the fourth year of the Jail Health Care Project in Wisconsin.

Since the program's inception in 1975, nine Wisconsin county jails have been accredited by the program for meeting basic health and medical care standards.

The most recent awards of accreditation went to six Wisconsin county jails on July 18 during the Annual Summer Meeting of the Sheriffs and Deputy Sheriffs Association in Land O'Lakes. The Dunn, Pierce, Racine, St Croix and Walworth County Jails received two-year accreditation from the program, while the Adams County Jail, awarded a one-year accreditation in 1978, received a two-year reaccreditation from the program.

Paul Glunz, MD, Beaver Dam, a member of the SMS Jail Health Care Committee, presented the awards.

The following physicians have participated in the Jail Health Care Program with their local county jails: Adams County—Martin L Janssen, MD, Adams; Dunn County—James E Willard, MD, Menomonie; Pierce County—Eugene R Jonas, MD, Ellsworth; Racine County—James B Shack, MD, Racine; St Croix County—Terry G Domino, MD, Hudson; Walworth County—Irwin J Bruhn, MD, Walworth.

The State Medical Society is interested in working with ten additional jails during the fourth year of the program. To accomplish this, letters have been sent to all county jails currently not participating in the program inviting them to do so. Any physician who is interested in improving the levels of health and medical care in his or her local county jail and would like more information on the SMS-AMA Jail Health Care Project should contact Parks Reinhardt at State Medical Society offices in Madison (toll-free: 1-800-362-9080).

Collection service available

Among the services available to SMS members is a safe, inexpensive debt collection program—one that has resulted in collections of more than $345 thousand for participating members. The program, offered by I. C. System, Inc., provides reputable collection assistance to physicians throughout Wisconsin. Members interested in learning more about I.C. can arrange to see a company representative by contacting the SMS offices or by calling I.C.'s regional office, collect, at 312/381-5881.

Fall family physician seminars approaching

Physicians are urged to take advantage of an outstanding educational opportunity by attending the "One-Day Seminars for Family Physicians" in Green Bay. Being sponsored again this year by the SMS Commission on Continuing Medical Education and the Fox Valley Chapter of the Wisconsin Academy of Family Physicians, the programs include: "A Day of Pediatrics" on September 9 at St Vincent Hospital; "A Day of Anemia and Chemotherapy" on October 17 at Bellin Memorial Hospital, and "A Day of Orthopedics and Emergency Treatment" on November 14 at St Vincent Hospital. For further information contact Arlene Meyer at SMS Madison offices (toll-free: 1-800-362-9080).

Mental Health Committee to seek AG Opinion

The SMS Mental Health Committee June 22 decided to seek an opinion from the State Attorney General regarding the applicability of a recent US Supreme Court decision to Wisconsin law concerning civil commitment of the mentally ill.

The high court's unanimous decision, in the case of *Addington vs Texas,* said a civil commitment proceeding did not require application of the criminal "proof beyond reasonable doubt" standard and held instead that "clear and convincing" evidence was constitutionally adequate.

"The reasonable doubt standard is inappropriate in civil commitment proceedings because, given the uncertainties of psychiatric diagnoses, it may . . . erect an unreasonable barrier to needed medical treatment," wrote Chief Justice Warren Burger in the court's opinion.

The Mental Health Committee is seeking the Attorney General's opinion because, according to Committee Chairman Charles Landis, MD, Milwaukee, "it is our concern that such unreasonable barriers to the civil commitment process do exist presently in Wisconsin."

FAS Awareness Project picking up steam

For hundreds of years there has been social and medical concern about the effects of alcohol on the fetus. Yet today we are still in the beginning stages of full, social, medical, and psychological research on this problem—a problem that has been formally named the fetal alcohol syndrome (FAS).

Last year State Medical Society physicians and the Society's Commissions on Public Information and Maternal and Child Health, targeted prevention of fetal alcohol syndrome in Wisconsin as a primary area of concentration for their health education activities. Society physicians have distributed thousands of brochures on FAS and have participated in a public education program to alert women of the potential dangers alcohol can have on their unborn babies.

At the same time, the State Department of Health and Social Services was recognizing that the problem was one which demanded immediate attention. DHSS Secretary Donald Percy authorized formation of a work group of interested health-related organizations and state agencies to provide women of childbearing age with information on FAS.

As a participant in this work group, the State Medical Society has been assisting in the development of a statewide public information campaign consisting of traditional media approaches; *ie,* newspaper articles, radio and television public service announcements, as well as more specialized approaches such as inclusion of the SMS mini-brochure on FAS in county marital packets.

Furthermore, the FAS message will be spread to more than 85,000 state employees in the state through FAS mini-brochure insertions in January paycheck envelopes.

Complementing the public information campaign, is an effort to train health practitioners on prevention of FAS in Wisconsin. In early fall, the *Wisconsin Medical Journal* will publish two articles on FAS: one dealing with the alcoholic woman and the other discussing prevention of fetal alcohol syndrome.

Similar articles are planned for allied health practitioner publications in Wisconsin including the *Wisconsin Pharmacist* and the Wisconsin Nurses Association's publication *STAT*.

Physicians may receive increased questions from their patients over the next few months concerning the hazards of alcohol consumption during pregnancy. It is important, therefore, that they be prepared for this possibility.

Physicians and other health care professionals, working with patients, can have a significant impact on decreasing the incidence of this and other tragedies related to alcohol abuse. ■

CONTRIBUTIONS CES FOUNDATION JUNE 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1979.

Unrestricted

SMS Members; Auxiliary to Winnebago County Medical Society; Auxiliary to LaCrosse County Medical Society; Auxiliary to Jefferson County Medical Society; Auxiliary to Waukesha County Medical Society—*Voluntary Contributions*

Restricted

Medical Associates-Beloit; Wausau Family Practice Center; Family Medical Clinic-Merrill; Wisconsin Rural Rehabilitation Corp; Employers Insurance of Wausau; Surgical Care-Blue Shield; MW Asplund, MD; Richland Medical Center; Osseo Medical Center-BG Garber, MD; Richard A Ellingstad, MD—*Medical Student Summer Externship Program*

Ayerst Laboratories—*Guest Speakers Fund*

Membership Dues—*Aesculapian Society*

Memorials

State Medical Society—*JC Griffith, MD; CR Marlewski, MD; JV Heil, MD; JA Russell, MD; AR Curreri, MD; AS Daniells, MD; CC Gascoigne, MD; WJ Waldschmidt, MD; Gunnar Gundersen, MD; John B Wear Jr, MD; William L Caldwell, MD*

Herman J Dick, MD; Jules D Levin, MD; Harry F Weisberg; G John Wier Jr, MD; Charles E Koepp, MD; Antoine Barrette, MD; Owen E Larson, MD; Russell F Lewis, MD—*John B Wear Jr, MD*

Mary Smigielski—*Herman A Whitson*

Dr-Mrs Leslie Jones—*Mr-Mrs James M Curry*

Dr-Mrs Richard Edwards—*John B Wear Jr, MD; Anthony Curreri, MD*

Mrs Marion P Crownhart; Robert B Murphy—*Gunnar Gundersen, MD (Crownhart Memorial Fund)*

HB Maroney II—*James Stokes (Barbara Scott Maroney Memorial Fund for Diabetes)*

Parks & Bill Reinhardt—*James Stokes (Museum of Medical Progress)*

Mrs Cyrus G Reznichek—*Ralph J Anderson (Reznichek Memorial Fund)*

Dr-Mrs Robert G Zach—*Dana Abbey (Aesculapian Society)*

Mr-Mrs Earl R Thayer—*Gunnar Gundersen, MD; John B Wear Jr, MD*

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of June 25, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/subspecialty)

County Medical Society

COLUMBIA-MARQUETTE-ADAMS

Daneshbod-Skibba, G, 1511 Park Ave, Columbus 53925 (1937, Regular, Pediatrics/Hematology, Certified-PD)

EAU CLAIRE-DUNN-PEPIN

Davidson, Robert E, 2712 Stein Blvd, PO Box 224, Eau Claire 54701 (1936, Regular, Pediatric Radiology/-Child Psychiatry, Certified-P)
Haemmerle, James H, 2211 Stout Rd, Menomonie 54751 (1947, Regular, Orthopedic Surgery)
Hirsch, Martin S, 2712 Stein Blvd, PO Box 224, Eau Claire 54701 (1944, Regular, Child Psychiatry/Psychiatry)

GREEN

Stiles, Frank C, 1515 10th St, Monroe (1921, Regular, Pediatrics, Certified)

KENOSHA

Azuma, Steven A, 6530 Sheridan Rd, Kenosha 53140 (1944, Regular, Obstetrics and Gynecology)

LACROSSE

Wilde, James G, 300 1st Street, South, La Crescent, MN 55947 (1950, Regular, Internal Medicine, Certified)

MILWAUKEE

Duncan, Thomas K, 2632 N Oakland Ave, Milwaukee 53211 (1950, Regular, Internal Medicine, Certified)
Matz, Dan, 4266 W Cherrywood Lane, Milwaukee 53209 (1945, Resident, Obstetrics and Gynecology)
Mirassou, Marlene M, 9191 Watertown Plank Rd, Milwaukee 53226 (1948, Resident, Psychiatry)
Rytel, Krystyna D, 1220 Dewey Ave, Wauwatosa 53213 (1934, Regular, Psychiatry)
Skibba, Carla A, 9033 W Grange Ave, Hales Corners 53130 (1940, Regular, Dermatology, Certified)
Walker, William E, 8535 W Capitol Dr, Milwaukee 53222 (1942, Regular, Internal Medicine)

WAUKESHA

Morzaria, Rasik N, N84 W16889 Menomonee A, Menomonee Falls 53051 (1943, Regular, Pediatrics, Certified)

WINNEBAGO

Adelman, Richard D, 400 Ceape Ave, Oshkosh 54901 (1949, Regular, Family Physician, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

BROWN

Bauer, Cynthia A W, Green Bay, to PO Box 27081, Milwaukee 53227
Bauer, Mark A, Green Bay, to PO Box 17061, Milwaukee 53227
Hinz, William M, Pensacola, FL, to Box 62 NAS Guam, FPO San Francisco CA 96637

DANE

Gomez, Robert C, Madison, to 515 NE Glen Oak St, Peoria, IL 61603
Larson, Christopher, Madison, to 1204 N 4th St, Sheboygan 53081

DODGE

Cook, R Sanford, Beaver Dam, to 17743 Raintree Terr, Boca Raton, FL 33431

EAU CLAIRE-DUNN-PEPIN

Thirakomen, Khamnung, Chippewa Falls, to 602 Manor Court, Altoona 54720

FOND DU LAC

Treffert, Darold A, Winnebago, to 459 East 1st St, Fond du Lac 54935

FOREST

Ovitz, Ernest G, Englewood, FL, to 5159 E Silver Lake Rd, Laona 54541

GRANT

Johnson, Larry W, Lancaster, to Medical College Ohio, CS 10008, Toledo, OH 43699

KENOSHA

Hill, Ben Spalding, Lighthouse Point, FL, to 7736 3rd Ave, Kenosha 53140

MILWAUKEE

Angel, John J, Mequon, to 2349 Kimbrough Woods, Germantown, TN 38183
Braun, James E, Wauwatosa, to 2213 Montclair Dr, Springfield, IL 62704
Claudon, Dann B, Milwaukee, to Rte #1, Box 50B, Oostburg 53070
Redlin, Russell R, Indio, CA, to 6440 Briarwood Lane, Waterford 53185
Steiger, Fredric A, Fort McClellan, AL, to 1908 Fairhaven Dr, Cedarburg 53012
Wagner, Thomas R, Milwaukee, to 500 A Vincent St, Stevens Point 54481
Williams, James D, Milwaukee, to Box 12, Bon Haven Dr, Maysville, KY 41056

ONEIDA-VILAS

Larson, Paul O, Rhinelander, to 6810 Winstone Dr, Madison 53711

OUTAGAMIE

Carlson, Guy W, Appleton, to 6209 Mineral Point Rd, #806, Madison 53704

WAUKESHA

Barber, Jergen L, Kalispell, MT, to 401 Windsor Dr, Waukesha 53186
Burke, Eugene P, Elm Grove, to 10625 West North Ave, Wauwatosa 53226

WOOD

Banerjee, Timir, Marshfield, to 4010 Dupont Circle, Louisville, KY 40207
Septer, Steven H, Marshfield, to 936 S Tennessee Pl, Mason City, IA 50401

DEATHS

Caldwell, William L, Dane County, May 21, 1979
Tucker, William J, Ashland-Bayfield-Iron County, May 29, 1979
Wear, John B Jr, MD, Dane County, May 25, 1979
Coffey, Sylvester E, Milwaukee County, June 18, 1979
Lorton, Rhoda E, Milwaukee County, June 21, 1979 ■

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Obituaries

◈County, State, AMA Members

◈ **Gunnar Gundersen, MD,** LaCrosse surgeon, died May 22, 1979 in LaCrosse. Born Apr 6, 1897 in LaCrosse, Doctor Gundersen graduated from Columbia University College of Physicians and Surgeons, New York, in 1920. Doctor Gundersen started in medical practice in LaCrosse in association with his father Dr Adolf Gundersen, founder of the Gundersen Clinic. He served as a member of the Board of Regents of the University of Wisconsin from 1931-1937; was president of the State Medical Society of Wisconsin in 1941-1942 and was president of the Wisconsin State Board of Health from 1943-1949. Doctor Gundersen also was a founding member of the Board of Directors of Blue Shield of Wisconsin and a charter member of the Joint Commission on Accreditation of Hospitals. He was a founder-member of the Wisconsin Surgical Society and a member of the World Medical Association and its Council for six years.

In 1953, Doctor Gundersen received the State Medical Society of Wisconsin's Council Award and in 1958 he received the 12th President's Award from the LaCrosse County Chamber of Commerce. He was speaker of the House of Delegates of the State Society from 1947 - 1949 and was a member of the Board of Trustees of the American Medical Association. In 1958 he became president of the American Medical Association. In 1966, the State Medical Society established the Gunnar Gundersen Gold Medallion Award to designate an outstanding teaching exhibit in connection with the Society's annual meeting, and to be granted to such as may merit in the years ahead.

The *Wisconsin Medical Journal* in 1969 published a special "festschrift" issue in his honor. Further comments of Doctor Gundersen's career appear in an adjacent column.

Surviving are his widow, Mary; one daughter, Mrs. Fredrik (Mary) Bugge, Oslo, Norway; two sons, Gunnar A, MD and Cameron B, MD of LaCrosse. Also surviving are one sister, Mrs C Fredrik (Helga) Midelfort, LaCrosse; and five brothers, Sigurd, MD; Alf, MD; Thorolf, MD all of LaCrosse; Trygve, MD, Boston, and Sven, MD of Hanover, New Hampshire.

◈ **Sylvester E Coffey, MD,** 74, Wauwatosa, died June 18, 1979 in Milwaukee. Born Oct 20, 1904 in Freedom, Wis, Doctor Coffey graduated from Marquette University School of Medicine in 1928. He served his internship at Milwaukee County General Hospital. Surviving are his widow, Ellen; three sons, Dr John M, Brookfield; Thomas J, San Francisco, Calif; Michael J, Menlo Park, Calif; and three daughters, Sylvia A, Chicago, Ill; Barbara A Nichols, Shorewood; and Pamela D Worra of Anchorage, Alaska. ■

Gunnar Gundersen, MD career highlights

As one of those pioneer physicians who helped shape the policies and direction of medicine in both the state and nation, Dr Gunnar Gundersen advocated: prepaid health insurance; scrapping compulsory retirement; holding the line on doctors' fees, hospital charges, and other health costs; warned physicians to guard against abuses of over-prescribing and overcharging simply because patients happen to have insurance protection; vehemently opposed the Kennedy Administration's proposal to tie health insurance for the elderly to the social security system; and supported continuing medical education for physicians.

As AMA president, Doctor Gundersen spoke often of putting compassion and warmth back into the age old art of medicine. He spoke of approval of the trend for human and spiritual factors in treating patients. As succinctly stated by the State Medical Society's Secretary, Earl Thayer:

"Medicine has lost one of its giants. Not only as an organizational leader, but as a conscience, as an inspiration, as an example of the best in physician care and concern for human welfare."

A CAREER HIGHLIGHT: Welcoming President Eisenhower (second from left) at the Atlantic City airport during Doctor Gundersen's AMA presidency (right). Also shown are Dr Leonard Larson (left) who was chairman of the AMA board of trustees, and Dr Louis M Orr (second from right) who was AMA president-elect.

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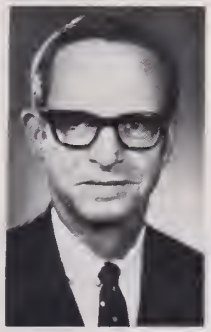
Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Jack A End, MD,* vice-president and corporate medical director of the Northwestern Mutual Life Insurance Company of Milwaukee, has been elected chairman of the board of the National Fund for Medical Education (NFME). The NFME board of directors consists mainly of top executives in corporations across the country. The NFME was organized in 1949 under the sponsorship of a group of university presidents (headed by Dwight D Eisenhower, then president of Columbia University), the American Medical Association, and the Association of American Medical Colleges, to mobilize support from the private sector for medical education. The Northwestern Mutual Life Insurance Company of Milwaukee is one of 53 insurance company contributors to the Fund which, since 1951, has awarded over $50 million in grants to institutions and organizations dedicated to medical education. One of four physician members of the NFME board is Leonard W Cronkhite Jr, MD, president of the Medical College of Wisconsin.



Doctor End

K W Emanuel, MD, Duluth, Minn, after 50 years of medical practice, retired on Feb 1. Doctor Emanuel graduated from the University of Wisconsin Medical School, Madison, in 1929 and is a founder of the West Duluth Clinic.

Robert S Merrill, MD, chief-of-staff at the Tomah VA Medical Center, recently was awarded the title of Honorary Member in the Wisconsin Academy of Physicians Assistants. Doctor Merrill, a graduate of the Washington University School of Medicine in 1946, was recognized for his efforts as an employer and clinical instructor for both the University of Wisconsin-Madison and the Marshfield Medical Foundation Physician Assistant training programs over the past four years.

Thomas J Rice, MD,* Marshfield Clinic specialist in obstetrics and gynecology, recently was the recipient of the "Max Fox Preceptor Award" from the University of Wisconsin Medical School. A physician with the Marshfield Clinic since 1951, Doctor Rice has taught nearly 200 students during his 27 years with the University of Wisconsin. The award was presented by Arnold L Brown, MD, dean of the UW Medical School, and Emeritus Professor Herman Shapiro, MD, who founded the award and dedicated it to Dr Max Fox. Doctor Fox was chief of Infectious Diseases for Milwaukee for several years.

Richard Stewart, MD,* Brookfield, professor of environmental medicine at the Medical College of Wisconsin, recently was honored for his pioneering role in developing the hollow fiber artificial kidney. Doctor Stewart's work was recognized at a founder's day luncheon at the annual meeting of the Society for Artificial Internal Organs held in New York. He graduated from the University of Michigan Medical School and began research as medical director for Dow chemicals. He joined the faculty of the Medical College of Wisconsin in 1966.

John R Litzow, MD,* Elm Grove, recently was appointed chief-of-staff at Deaconess Hospital, Milwaukee. Doctor Litzow has been on the medical staff at Deaconess Hospital for 10 years and has been acting chief of medicine since June 1978. He fills the position formerly held by Richard P John, MD, Brookfield, who has been appointed medical director at Deaconess.

Richard E Zellmer, MD,* West Bend, recently was elected president of the medical staff of St Joseph's Community Hospital. Other officers elected are MDs R D Gibson,* vice-president, and R T Bodensteiner,* secretary-treasurer.

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Surinder K Rajpal, MD, Manitowoc, recently became associated with the Manitowoc Clinic in the practice of pediatrics. A 1965 graduate from the University of East Africa in Uganda, he interned in surgery and internal medicine at the Kenyatta National Hospital, Kenya. He completed his pediatric residency at Milwaukee Children's Hospital.

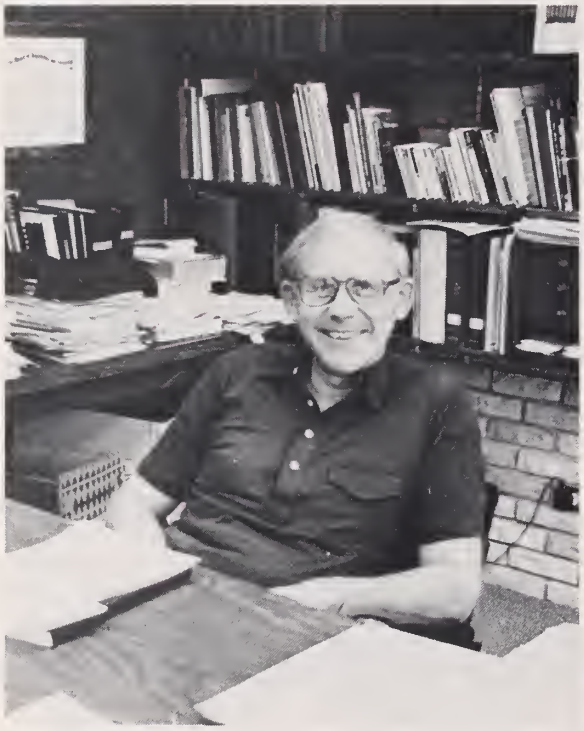
Frederico P Gregorio, MD, recently joined the medical staff at Neillsville Memorial Hospital in the department of surgery. Educated in The Philippines, Doctor Gregorio has practiced in the United States for the past eight years. He interned at Mesericordia Hospital, Philadelphia, Pa, and was a resident surgeon at Mercy Catholic Medical Center, Darby, Pa. Doctor Gregorio also practiced surgery in New Town, Pa.

Howard T Chatterton, MD, recently began his medical practice in family medicine at the Ladysmith Medical Center. He graduated from Duke University Medical School, Durham, NC, where he also completed his family practice residency.

Vinoo Cameron, MD, recently became associated with the Iola Clinic, SC. Doctor Cameron has had residency training in general surgery, orthopedic surgery, and emergency medicine in England and India. He also spent another two years in a surgical pathology residency at Madison.

Vicki R Prell, MD, an otolaryngologist, has joined the medical staff at Beaver Dam Community Hospital-Hillside Unit. She interned at St Luke's Hospital, Milwaukee, and completed her residency with the affiliated Medical College of Wisconsin Hospital.

Thomas R Wagner, MD,* Stevens Point, recently opened his medical practice in general and vascular surgery. Prior to moving to Stevens Point, Doctor Wagner had practiced for six years in Milwaukee. A graduate from Marquette University School of Medicine, he served his internship and residency in St Paul, Minn, and Milwaukee. He also served in the United States Air Force for two years.



Darold A Treffert, MD* (above), recently resigned as administrator of Winnebago Mental Health Institute, a position he has held for 15 years. Doctor Treffert has become the director of the Fond du Lac County Medical Health Center and program/clinical director of the Fond du Lac County Unified Board. Along with his new position in Fond du Lac, he will continue his private practice. Doctor Treffert also is the president of the State Medical Society of Wisconsin for the year 1979-1980. (Photo by *Oshkosh Daily Northwestern)*

Frederick Pitts, MD* and his wife, Lavilla, are shown above packing up their belongings and leaving for Costa Rica. Doctor Pitts, neurosurgeon and former chief-of-staff of Madison General Hospital, practiced medicine in Madison for 20 years before leaving his medical practice to become a sheep rancher on an expanse of mountains and plains just 16 kilometers outside San Jose, Costa Rica. (Photo courtesy of Shiela Reaves/*Capital Times)*

Gary Bridgewater, MD, Madison, recently became the medical director of the DeForest Clinic. He graduated from the University of Illinois Medical School and served his internship in Boston. His residency in internal medicine was served at the University of Wisconsin Hospitals, Madison. Doctor Bridgewater also is a medical consultant at the Oakhill Correctional Institute, Oregon.

Ralph E Schenck, MD, recently joined the medical staff of the Flyway Medical Center, Mayville. Doctor Schenck is a graduate of the University of Western Ontario Medical School and served his residencies at Methodist Hospital in Indianapolis, Ind. He previously practiced in Portland, Ind. Doctor Schenck served as a fighter pilot in the Royal Air Force and member of the Flying Physicians Association.

Edward R McNair, MD,* Orfordville physician for the past 40 years, recently was honored by the community for his services at a "Dr McNair Day." Doctor McNair graduated from Rush Medical School in Chicago and interned at Blodgett Memorial Hospital, Grand Rapids, Mich. He has been in the medical field for 50 years and 40 years has been in the Orfordville area.

Curtis W Hancock, MD, Sheboygan, recently joined the medical staff of the Sheboygan Clinic. He graduated from the University of Wisconsin Medical School and served his internship and residency at Bronson and Borgess hospitals, Kalamazoo, Mich. Doctor Hancock, an internal medicine specialist, also served in the United States Army in Seoul, Korea, from 1969-1972.

Edward J Kramper, MD will be opening a medical practice in McFarland Sept 1. He received his MD degree from the University of Missouri in 1976 and completed his family practice residency at Creighton University, Omaha, Neb. A member of the AAFP, Doctor Kramper also has completed a training program in obstetrics at Women's Hospital, associated with the University of Southern California.

Richard G Nash, MD, recently became associated with the Ladysmith Medical Center. A family physician, Doctor Nash graduated from the University of Minnesota Medical School and completed his family practice residency in Duluth.

John L Claude, MD,* member of the Wilkinson Clinic, Oconomowoc, since 1954, recently joined the United States Army and is based at a small hospital in Augsburg, West Germany. A gynecologist, Doctor Claude will be serving in the Army for the next three years. His wife and four of his seven children have accompanied him to West Germany. He was given the status of Lt Colonel and after his discharge will return to the Wilkinson Clinic. ■

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Milwaukee, Wisconsin 53213
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Reuben & Margaret Filter
Beltone Hearing Aid Center
2223 Church Street
Stevens Point, Wisconsin 54481
(715) 341-4250

Beltone Hearing Aid Center
940 19th Street, South
Wisconsin Rapids, Wisconsin 54494
(715) 423-1815

Rex V. Gassen
Beltone Hearing Aid Center
1531 Losey Blvd.
LaCrosse, Wisconsin 54601
(608) 788-4460

Jack Morrison
Beltone Hearing Aid Service
N92 W17420 Appleton Avenue
Menomonee Falls, Wisconsin 53051
(414) 255-3400

Clem & Helen Ogurek
Beltone Hearing Aid Center
214 Maple Street Box 1703
Wausau, Wisconsin 54401
(715) 842-9882

Gail & Patricia Serig
Beltone Hearing Aid Service
424 So. Park Street
Madison, Wisconsin 53715
(608) 256-6440

Beltone Hearing Aid Service
17 So. River Street
Janesville, Wisconsin 53545
(608) 754-2561

William Valade
Beltone Hearing Aid Service
Washington Square Building
5200 Washington Avenue
Racine, Wisconsin 53406
(414) 637-5668

Beltone Hearing Aid Service
2122 22nd Street
Kenosha, Wisconsin 53140
(414) 552-8070

Robert & Vi Williams
Beltone Hearing Aid Service
44 South Marr Street
Fond du Lac, Wisconsin 54935
(414) 922-6640

Beltone Hearing Aid Service
1733 North 8th Street
Sheboygan, Wisconsin 53081
(414) 452-0641

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Specialty Societies

WISCONSIN SURGICAL SOCIETY: The fall meeting of the WSS will be held at the new University of Wisconsin Hospital and Clinics, Friday and Saturday, September 14-15, in Madison. Current officers are: President—Walton D Thomas, MD, Milwaukee; past president—Edward A Bachhuber, MD, Mayville; president-elect—Charles E Yale, MD, Madison; secretary-treasurer—Richard B Windsor, MD, Sheboygan; and recorder—Johan A Mathison, MD, Oshkosh. Members of the Council are: George M Kroncke, MD, Madison (1980); Robert G Isom, MD, Oshkosh (1980); Louis C Bernhardt, MD, Madison (1981); Gale L Mendeloff, MD, Milwaukee (1981); Earl B Kitzerow, MD, Appleton (1982); and Stuart D Wilson, MD, Milwaukee (1982). Officers of the Section on Surgery of the State Medical Society of Wisconsin are: president—Walton D Thomas, MD, Milwaukee; past president—Edward A Bachhuber, MD, Mayville; president-elect—Charles E Yale, MD, Madison; and secretary—Richard B Windsor, MD, Sheboygan.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY: The forthcoming speakers for the Milwaukee Ophthalmological Society meeting year are listed below. All interested ophthalmologists and their guests are cordially invited to attend. Meetings are held at the University Club, 924 East Wells, Milwaukee, Wisconsin. The meeting format: social time 5:15 pm, business meeting 6:00 pm, dinner 6:30 pm, and scientific program 7:30 pm.

Oct 23, 1979—Dr George Garcia-Boston: "Advances in Optics and Optical Appliances (Contact Lenses)."

Nov 27, 1979—Dr Howard Schatz/San Francisco: "Changing Understanding of Retinal Vascular Pathology."

Jan 22, 1980—Dr Ronald Radius/Medical College of Wisconsin: "Therapeutic Decisions in Glaucoma."

Feb 26, 1980—Dr Robert Brockhurst/Boston: "Advances in Diagnosis in Diseases of the Retina and Retinal Detachment."

Apr 22, 1980—Dr Ronald Kalkhoff/Professor of Medicine and Director of Metabolic Service, Medical College of Wisconsin: "Medical Advances in the Diagnosis and Treatment of Diabetes Mellitus."

Surgeons program on cost-containment. Members of the Florida Association of General Surgeons approved a ten-point program to try to keep down the cost of medical care. It has been distributed to its membership by the Wisconsin Chapter of the American College of Surgeons. The ten-points follow:

1) To limit increases in our fees to only those made necessary by increased costs of practice and living.
2) To use all methods available to make our delivery of medical care more efficient.
3) To use office care, home care, nursing home care, and outpatient care facilities as much as possible, and to admit patients to the hospital only when proper treatment cannot be done elsewhere.
4) To examine our indications for operation critically and to seek consultation with another surgeon without hesitation in any questionable situation.
5) To utilize preadmission diagnostic studies and therapy as much as possible in order to decrease the time between hospital admission and operation.
6) To employ only those diagnostic and therapeutic modalities which are necessary to proper care of the patient.
7) To avoid the use of "defensive medicine" unless it truly improves the quality of care.
8) To make every patient's hospital stay as brief as possible.
9) To review periodically, on a regular basis, our patients' hospital bills so that we are kept up to date on the cost.
10) To share these aims with other members of the medical profession so that our efforts will have maximum effect.

News Highlights

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

St Joseph's Hospital, Wauwatosa, recently honored the following physicians for a quarter or a half century of service as members of the medical staff. MDs John J Brennan,* Department of Obstetrics-Gynecology, and Kendall E Sauter,* Department of Surgery and Director of Medical Education, were presented with 25-year certificates. Recipients of 50-year plaques were MDs Joseph M King,* Department of Surgery; Edwin P Bickler,* Leonard J Schneeberger,* and Arthur H Thorstensen,* Department of Family Practice; and Michael Kuhn Sr, Department of Obstetrics-Gynecology.

The Medical-Surgical Clinic, Milwaukee, recently paid tribute to Barney B Becker, MD* for his 25 years of service. Doctor Becker, a general and thoracic surgeon, joined the occupational and private care clinic's founders, Doctors Weisfeldt and Rothman in 1952. He is now the longest tenured physician at the Clinic. Doctor Becker completed his medical training at the University of Wisconsin Medical School, Madison. He has served as secretary for the Medical Society of Milwaukee County and also as chief of surgery at Mt Sinai Medical Center.

St Joseph's Hospital, Chippewa Falls, recently announced the reelection of Ralph C Frank, MD,* radiologist, as president of its medical staff. MDs Warren K Wright,* pathologist, and Reynaldo C Maniquiz,* internal medicine, were reelected vice-president and secretary-treasurer, respectively. Doctor Frank has been a member of the medical staff since 1949 and Doctors Wright and Maniquiz have been members since 1971. Also reelected were MDs R L Hendrickson,* chairman, Department of General and Family Practice; S B Lee,* chairman, Department of Obstetrics; L W Picotte,* chairman, Emergency Medicine; and C R Gonzaga* as chairman of the Department of Surgery.

The American College of Radiology has announced that the following Wisconsin physicians will be named fellows in ACR at the annual meeting to be held in Chicago in September. The MDs to be recognized are Wylie J Dodds, Brookfield, a 1960 graduate of Cornell University Medical College, New York; Adam Fueredi,* Cedarburg, 1961 graduate of The Medical College of Wisconsin, Milwaukee; John R McKenzie,* Oshkosh, 1955 graduate of The Medical College of Wisconsin; and Ismail N Nevin, Rhinelander,* a 1951 graduate of Yale University School of Medicine, New Haven, Conn.

The Southeastern Wisconsin Chapter of the National Multiple Sclerosis Society recently named two Wisconsin physicians to its Medical Advisory Board. The MDs are Marc Novom, Glendale, and Arthur Turner,* Whitefish Bay. The Medical Advisory Board primarily is involved in planning, directing, and giving medical approval to all patient service programs which subsequently are submitted to the Chapter Board for approval and funding. ■

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Expanding role of mammography

OPTIMAL PATIENT CARE should be the primary concern, but in many hospitals and clinics the mammography patient is run through the radiology department without ever meeting the radiologist. Frequently, it is standard procedure to have an x-ray technician take routine mammogram views only for the radiologist to read at a later date in an impersonal, uninformed, and possibly inaccurate manner.

We believe that the mammography patient should be examined individually and allotted time for complete evaluation. Mammography is an area of radiology that requires patient contact and should include pertinent clinical history, physical examination, films, and/or xerograms of the area of concern, as well as other available diagnostic procedures, if indicated.

Physical and mammographic examinations of the breast are complementary and should be considered together in decision making. Mammography should confirm the physical findings when present and add information for differential diagnosis. At the same time, each mode of evaluation must be considered seriously and independently, because it may or may not indicate that the surgeon should obtain a biopsy.

In general, when a mass is present, benign lesions have similar dimensions both clinically and radiographically. By contrast malignant lesions tend to appear smaller on mammograms but feel larger clinically due to peritumoral infiltration. Minimal discrepancy between physical and radiological findings should alert the radiologist to follow up with a breast ultrasound to confirm the disproportion. Obviously, if a physical examination were not performed, this sign could readily be missed.

Even when a significant mass is not present, a physical examination should still be performed by the radiologist because with experience it is possible to palpate a lesion as small as 1 cm if it is reasonably superficial. Recent data[1] confirm that 33% of early breast carcinomas can be detected clinically. Therefore, it is a gross disservice to delete physical examinations from the mammographic evaluation.

The mammography section of a radiology department no longer has as its sole responsibility the taking of mammograms. There are other radiographic diagnostic procedures available such as breast ultrasound, galactography, cyst aspiration, pneumocystograms, preoperative needle localization of clinically occult lesions, and specimen radiography. The scope of the mammography unit must be broadened to encompass the function and potential diagnostic capabilities of these other under-utilized examinations. A great deal of definitive information can be obtained from these procedures which may possibly prevent the patient from undergoing unnecessary surgery.

For cases of nipple discharge in patients over 50 years of age, galactography with two screening lateral projections should be the procedure of choice because mammography alone has only a 20%[2] accuracy rate in defining this problem. Unfortunately, because galactography is believed to be rather time consuming and tedious to perform, it is not routinely obtained in patients with nipple

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

secretions. Actually it requires only a reasonable amount of dexterity and expertise.

If the radiologic and/or clinical findings are equivocal, breast ultrasound is a safe, informative alternative that can add further dimension and perspective to the problem. This method of evaluation is particularly useful for patients in the 20-30 year age bracket who generally have dense breast tissue. Breast ultrasound is able to differentiate between solid and cystic lesions, as well as visualizing the mass outline. Also on ultrasound, many types of malignant lesions appear denser than normal glandular tissue.

At times, a patient with a clinically detected mass will present minimal mammographic findings on routine examination. By supplementing with additional views and techniques, such as lateral-medial, negative mode, etc, clarification is enhanced, and more confident diagnosis can be made.

Also of concern are deep-seated cystic lesions which may clinically resemble carcinomas. Mammographic and ultrasonic examination followed by cyst aspiration will allow the exact nature of the problem to be determined. If bloody intracystic fluid is aspirated, then a double contrast pneumocystogram is warranted.

A recent NIH-NCI study of 445,048 women revealed 592 minimal breast cancers, of which 95% were detected by mammography. These are impressive statistics, but we feel they can be improved by having the radiologist enlarge the parameters of the original mammogram concept. By incorporating the relevant clinical history, physical findings, mammographic reading, plus utiliztember 24, at Wisconsin Center in Madison.
ing various supplemental diagnostic procedures currently available, a more accurate and educated interpretation of the patient's condition can and should be accomplished.—RAUL H MATALLANA, MD, Dept of Radiology and Wisconsin Clinical Cancer Center, Center for Health Sciences, Madison.

REFERENCES

1. NIH-NCI Consensus Development Meeting on Breast Cancer Screening-Special Report. *Am J Radiol* 130:194-197, 1978.
2. Dodd GR: Multidisciplinary approach to breast cancer in a categorical institution. Seminar on the Team Approach to Early Diagnosis of Breast Cancer. Newark, New Jersey, December 19, 1970.

Don't forget—

- Midwest Cancer Seminar, September 20-22, at the Concourse in Madison.
- Midwest Oncology Nursing Conference, Sep-
- See the YELLOW PAGES for details. ■

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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April 19

Medical Yellow Pages

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Physicians Exchange

PHYSICIAN(S) INTERESTED IN family practice to locate in Baldwin, Wis. Excellent hospital facilities located adjacent to Clinic. Offers excellent family environment and a variety of recreational activities. 40 minutes east of St Paul, Minn. Contact Gordon Palmer. Admin, Baldwin Community Hospital, Baldwin, Wis 54002. Tel: collect 715/684-3311. 7-9/79

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WANTED: TWO FAMILY PHYsicians preferably ABFP for association with the Family Medical Center, Sheboygan, Wisconsin. Please call or write: Martin A Rammer, MD, 1930 N 8th St, Sheboygan, Wis 53081; phone 414-457-5016. 5tfn/78

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RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

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WANTED: PRIMARY CARE physicians interested in full or half-time employment with the Department of Health and Social Services, Division of Health. Assisted by excellent nursing staff, these physicians will render quality health care to adult and juvenile residents of Wisconsin correctional institutions located throughout the state. Excellent salary and fringe benefits. Malpractice insurance paid. For more information, contact Hania W Ris, MD, 110 East Main St, Room 608, Madison, Wis 53703. 608/266-5718. An Equal Opportunity Employer Functioning Under An Affirmative Action Plan. 7-8/79

WANTED: GENERAL SURgeon, orthopedic surgeon, urologist, and ENT physician to join a group of nine family practitioners, one general internist in a rural community in northeastern Wisconsin. For additional information, contact Lloyd Cotts, MD, Rice Lake, Wis. Tel: 715/234-9031. 8-10/79

WANTED—URGENT CARE physician to handle walk-ins and some occupational medicine for 25 physician clinic in east-central Wisconsin. For more information send curriculum vitae to Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935. 8-9/79

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- Obstetrician-Gynecologist
- Family/General Practitioner

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 7tfn/79

INTERNIST—THIS IS A FINE opportunity to join a five-man, well established, internal medicine group with both downtown Milwaukee and suburban offices for someone either in solo practice or completing residency. Excellent starting salary, fringe benefits, hospital associations, and teaching appointments. Please send curriculum vitae to Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 8-11/79

EMERGENCY ROOM PHYSICIAN needed: Fox River Valley. 32-hour week, $80,000 plus. Includes many fringes. Send resume to Box 1424, Green Bay, Wis 54305. Tel: 414/855-6159. 8-9/79

CAREER ORIENTED ER PHYSICIAN needed immediately in southeastern Wisconsin city of 80,000 on Lake Michigan between Chicago and Milwaukee. Multispecialty backup. Excellent nursing staff. Starting salary in excess of $70,000 per year based on 42-hour week. Send CV to Emergency Room Associates, 7743 Third Ave, Kenosha, Wis 53140. 8-10/79

FAMILY PRACTICE, ENT AND Internal Medicine positions available with a 15-man multispecialty group corporate practice. Modern clinic facility in northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 8-11/79

GENERAL PRACTICE AVAILable. One or two doctor group. Location downtown, city of 5,000. New hospital. Arrangement can be made accordingly to take over practice and equipment. Contact Dept 469 in care of the Journal. 8-9/79*

WISCONSIN — FAMILY PRACtice physician wanted, incorporated clinic group of five, including Family Practice and General Surgery. Ideal town in northern Wisconsin, 35 miles from Minneapolis. Income guaranteed first year. Contact J Craig, New Richmond Clinic, SC, New Richmond, Wis 54017 (715)/246-6911). 7-11/79

WANTED MEDICAL SPECIALties — small town between Milwaukee and Chicago serving a shopping area population of 50,000. Has 140-bed hospital, 14 GPs, 3 OB/GYNs, 1 ophthalmologist and 1 orthopedic surgeon. Custom built office space in superbly located new building. For full details contact Arthur L McCourt, 148 S Pine St, Burlington, Wis 53105. Tel: 414/763-7697. 4-9/79

PRIMARY CARE PHYSICIAN needed to join established and expanding semi-rural primary care center located within 20 miles of Madison, Wisconsin. Two additional PRIMARY CARE PHYSICIANS needed by summer 1980 for newly developing center also located within easy drive of Madison. A professional advisory group, Health Care Associates, provides management and support services with emphasis on problem-oriented system. Minimum compensation guarantee and opportunity to purchase practice within two to five years. Send curriculum vitae to J M Nelson, MD, 202 South Park St, Madison, Wis 53715. Tel: 608/267-6320. 8-10/79

INTERNIST AND CERTIFIED nurse-midwife seek positions in small town or city (5,000-50,000) partnership or group practice preferred. Call J Elisberg, MD, 612/224-3711 or Karen Elisberg 612/644-8123. p8/79

Medical Facilities

NEW PRESTIGIOUS OFFICE building in Glendale. Easily accessible location, Green Bay Avenue near Good Hope Road. Good parking plan, access to building and interior circulation including elevator. Office suites can be planned for individual requirements. Call 414/961-1196. 6-8/79

FOR SALE: THREE-YEAR-OLD Select-A-Fuge No 805, one unimeter 300 Distributor Bio-dynamics in excellent condition. Retiring from practice. Reasonable. Tel: 715/275-3785. PO Box 8, Elcho, Wis 54428. p8/79

FOR SALE: ULTRASONIC therapy unit. Burdick model UT-1, No v-101-Serial 1965, watts 20 per square cm. Contact Mrs Long, 2435 W Greenwood Rd, Glendale, Wis 53209. g6tfn/79

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOR SALE: 50 YEAR EENT—90% eye practice. Southside Milwaukee suburb. Physician retiring. 921½ Milwaukee Ave, South Milwaukee, Wis 53172 or call 414/762-3730. 6tfn/79

FOND DU LAC FACILITY. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

WANTED: USED X-RAY EQUIPment, accessories, ultrasonic and diathermy equipment. Call 414/444-7125. 5tfn/79

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

MEDICAL SUITE AVAILABLE, first floor, 1200 sq ft including reception area, 3 examining rooms, consultation room, lab, 2 bathrooms. Adjacent to Villard Pharmacy, 54th and Villard, Milwaukee, Wis 53218. Phone 414/461-2155 or 414/352-0135. 8-9/79*

LOT FOR SALE: ELM GROVE lot $70,000. Cul de sac heavily wooded. 13850 Watertown Plank Rd. Tel: 414/257-3103. 7-8/79

Allied Health Services

POSITION WANTED: PHYSIcian assistant. August 1979 graduate of Duke University PA program. Thirty-two year old married male seeking return to Wisconsin and interested in family practice setting. Available mid-August 1979. Contact: John O'Brien, Flint Ridge #65, Hillsborough, NC 27278. Tel: 919/732-4022 (evenings). p6-8/79

CERTIFIED NURSE-MIDWIFE with training in normal OB, office GYN, and family planning; seeks position with FP or OB/GYN in small town or city (5,000-50,000) Call Karen Elisberg, 612/644-8123, evenings. p8/79

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1979 Wisconsin

Sept 8: Wisconsin Allergy Society Annual Meeting, Pioneer Inn, Oshkosh. *Pulmonary Function,* by Reuben Cherniak, MD, Denver, CO, and *Newer Development in Stinging Insect Therapy,* by Martin Valentine, MD, Baltimore, MD. 4 hours CME credit. Info: Morton M Soifer, MD, 707 West Glencoe Pl, Milwaukee 53217. Tel: 414/351-4445.

Sept 12, 13, 26, 27: *Health Care and the Aging;* seminars on long-term care presented by Wisconsin Health Care Review, Inc (WHCRI). See details in box elsewhere in this section.

Sept 14-15: *Urology for Family Practitioners,* at Clinical Science Center, UW-Madison. Lectures, discussions, and case presentations aimed at updating the family practitioner's knowledge of common urologic problems, how they are diagnosed, and how they are best treated. Fee: $45. Further info: Sarah Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

Sept 13-15: Wisconsin Society of Internal Medicine, Playboy Club, Lake Geneva.

Sept 13-15: Wisconsin Regional Meeting, American College of Physicians, Lake Geneva Playboy Club, near Milwaukee. Designed to bring physicians up-to-date on late developments in the field of internal medicine. Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physician's Recognition Award in Category I. In charge of planning for the ACP's Wisconsin Regional Meeting is Charles L Junkerman, MD, who serves as the medical specialty society's representative in Wauwatosa. Info: Charles L Junkerman, MD FACP, 831 N 66th St, Wauwatosa, Wis 53213.

Sept 14-16: Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Sept 19: One-Day Seminar for Family Physicians, St Vincent Hospital, Green Bay

Sept 20-22: *Midwest Cancer Seminar,* The Concourse, in Madison, sponsored by Wisconsin Clinical Cancer Center and others. See details elsewhere in this section.

Sept 21-22: *Medical and Surgical Management of Coronary Artery Disease* Conference, at St Mary's Hospital Medical Center, Madison. Approved for 10 hours of AMA Category 1 credit. Conference co-directors: Louis C Bernhardt, MD, FACC, Associate Clinical Professor of Surgery, and James E Gutenberger, MD, Assistant Clinical Professor of Surgery, University of Wisconsin Medical School, and Dept of Thoracic and Cardiovascular Surgery, St Marys Hospital Medical Center; and Robert R Henderson, MD, FACP, Assistant Clinical Professor of Medicine, UW Medical School, and Medical Director of Cardiology, St Marys Hospital Medical Center, Madison. Guest Faculty: Mortimer J Buckley, MD, FACC, Chief, Cardiac Surgical Unit, Massachusetts General Hospital, and Professor of Surgery, Harvard Medical School; James S Forrester, MD, FACC, Assistant Director of Cardiology, Cedars Sinai Medical Center, Los Angeles; Adolph M Hutter Jr, MD, FACC, Associate Director, Coronary Care Unit, Massachusetts General Hospital, and Associate Professor of Medicine, Harvard Medical School; and Floyd D Loop, MD, FACC, Chairman, Dept of Thoracic and Cardiovascular Surgery, Cleveland Clinic Foundation, Cleveland. (Football Saturday: Wisconsin vs UCLA.) Registration fee: $55. Info: Sarah Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

Sept 24: Wisconsin Clinical Cancer Center's Second Annual Midwest Oncology Nursing Conference, at The Wisconsin Center, in Madison. See details elsewhere in this section.

Oct 8-10: *Applied Immunology in Clinical Medicine,* American College of Physicians Postgraduate Course, Medical College of Wisconsin, Pfister Hotel, Milwaukee. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa.

Oct 10: *Neurology Update*—One-day seminar for family practitioners, internists, and other interested physicians. Sponsored by Theda Clark Regional Medical Center, Neenah. At Valley Inn, Neenah. Faculty: Michael P McQuillen, Chairman, Division of Neurology, Medical College of Wisconsin; H A Majid, MD, Michael Rieder, MD, M A Letellier, MD, Neurologic Associates. Contact Paul B McAvoy, MD, phone 414/725-7071.

Oct 13-14: *Advanced Cardiac Life Support,* Wisconsin Chapter, American College of Emergency Physicians in cooperation with the American Heart Association. Milwaukee, Wis. 12 hrs Category I PRA-AMA. Fee: $150. Info: Gary Gerschke, MD of Emergency Medicine, Columbia Hospital, 2025 East Newport, Milwaukee 53211. Tel: 414/961-3508.

Oct 15-16: *Neurologic Aspects of Pediatric Disease,* Playboy Club and Resort, Lake Geneva. (Further details appear elsewhere in this section.)

Oct 17: One-Day Seminar for Family Physicians, Bellin Memorial Hospital, Green Bay.

Oct 17-19: Seminar/Workshop on Genitourinary Radiology, The Olym-

pia, Oconomowoc. Approved for Category 1 credit of PRA-AMA. Info: Lyn Opelt, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Oct 19-20: 23rd Annual Clinic Day Program: Colorectal Carcinoma: Medical and Surgical Aspects of Diagnosis and Treatment. Approved for 6 hrs Category I CME/AAFP credit. Info: Medical Education Office, St Joseph's Hospital, 5000 W Chambers St. Milwaukee, Wis 53210.

Nov 9: 18th *Annual Medical-Legal-Industrial Symposium: Cancer and Industry*, Pfister Hotel, Milwaukee. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee 53201. Tel: 414/289-8200.

Nov 14: One-Day Seminar for Family Physicians, St Vincent Hospital, Green Bay.

1979 Neighboring

Sep 16-20: American College of Radiology, Chicago.

Sept 26-28: *Health Decisions of the 80s*, joint conference on occupational health, at Radisson Downtown Hotel, Minneapolis. Registration fees $35 for American Academy of Occupational Medicine and American Academy of Industrial Hygiene members and $45 for nonmembers. Further info: American Academy of Occupational Medicine, 150 North Wacker Drive, Chicago, Ill 60606; phone 312/782-2166.

Neurologic Aspects of Pediatric Disease

Playboy Club and Resort
Lake Geneva, Wisconsin

Oct 15-16, 1979

Sponsored by The Medical College of Wisconsin and Milwaukee Children's Hospital

Guest faculty:
William E Bell, MD
Bernard J D'Souza, MD
Norman Fost, MD
Gerald P Koocher, PhD
John M Opitz, MD
N Paul Rosman, MD

Approved for 14 hrs of Category I credit of PRA-AMA and AAFP.

Info: Ms Jennie M Evenson, Dept of Neurology, The Medical College of Wisconsin, Milwaukee Children's Hospital, PO Box 1997, Milwaukee, Wis 53201. Tel: 414/931-4074.

Sept 28: Hand Symposium, Bethesda Lutheran Medical Center, St Paul, Minn. See details elsewhere in this section.

Oct 13-17: Indiana State Medical Association, Sheraton West, Indianapolis. Info: D F Foy, 3935 N Meridian St, Indianapolis, IN 46208. 248. Price: $9.00.

1979 Others

Oct 1-4: American College of Emergency Physicians, Hyatt Regency, Atlanta, Ga. Info: A E Auer, 3900 Capital City Blvd, Lansing, Mich 48906.

HEALTH CARE AND THE AGING

Seminars on Long-term Care

Statewide seminars on the health-care of the long-term care resident will be presented by

Wisconsin Health Care Review, Inc (WHCRI)

Wednesday/Sept 12/Madison

Thursday/Sept 13/Eau Claire

Wednesday/Sept 26/Green Bay

Thursday/Sept 27/Milwaukee

Topics include:

—*Restorative Potential—SNF Resident.* Speakers: David P Kuter, MD; Mary Willis, RN, MSN, NP; and Celia Lamper, RN, MSN, PNP

—*The Medical Director.* Speaker: Nicholas Owen, MD

—*Documentation—Medical Records.* Speaker: John M Kraft, MD

—*Annual Medical Reviews.* Speaker: Frank A Walker, MD

These one-day seminars will be of special interest to physicians involved in long-term care (medical directors, attending physicians), nurses, nursing home administrators, and social workers.

Registration information may be obtained by contacting: Wisconsin Health Care Review, Inc, 330 East Lakeside St, Madison, Wis 53715; (608) 257-6781, ext 151

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION

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New Orleans
November 5-8, 1979

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- 24 hours Category 1 credit, PRA of the AMA
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- Special events and tours

For registration materials and program, return the form below to Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701

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City .....

State .....Zip .....

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- Introduction to antitrust law
- Introduction to antitrust enforcement
- Medical staffs
- Hospital mergers and consolidations
- Multi-institutional ventures
- Participation in the regulatory process
- Private planning
- Professional codes of ethics
- Accreditation and licensure
- Third-party providers and payors

Faculty:
- Phillip A Proger, JD, Attorney, Baker & Hostetler, Washington, DC
- Jack C Wood, JD, Principal, Wood, Lucksinger and Epstein, Chicago, Ill. Past President of American Society of Hospital Attorneys

Seminar fee information:
- All seminars are 2 1/2 days in duration
- Tuition is as follows: Single registrant — $350; two or more from same institution (when registering for the same session of the seminar at the same time), per registrant—$310

For further information and registration forms: Registrar, Aspen Systems Corp, 20010 Century Blvd, Germantown, Md 20767; or call: (301) 428-0700

1979 Others

continued

Oct 5-7: Michigan Regional Meeting of American College of Physicians, Boyne Highlands Lodge, Harbor Springs, Mich. Info: Boy Frame, FACP, 543 Lakepointe, Grosse Pointe Park, Mich 48230.

Oct 7-11: American Academy of Otolaryngology, Convention Center, Dallas, TX. Info: C M Kos, MD, 15 Second St SW, Rochester, Minn 55901.

Oct 11: Symposium on hypertension for family physicians entitled "Hypertension in Family Practice: Present and Future." A special presentation immediately following the Annual Meeting of the American Academy of Family Physicians, at Georgia World Congress Center, 285 International Blvd NW, Atlanta, Ga. Acceptable for 3 prescribed hours by the American Academy of Family Physicians and approved for 3 credit hours in Category 1 for the PRA-AMA. Info: World Health Information Services, Inc, 505 Park Ave, New York, New York 10022; phone 212/751-5737.

Oct 25-27: International Conference on *Legal Aspects of Health Care for Children*, at Four Seasons Hotel, Toronto, Ontario, Canada. Info: American Society of Law & Medicine, 520 Commonwealth Ave, Suite 211, Boston, Mass 02215.

Nov 7-11: American Medical Women's Association, Albuquerque Hilton, Albuquerque, NM. Info: L Loesel, 1740 Broadway, New York, NY 10019.

NATIONAL MEDICAL SPECIALTY SOCIETIES

1979 Meeting Dates/Sites

Sept 16-20: American College of Radiology, Chicago, Ill.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

Oct 7-11: American Academy of Otolaryngology, Convention Center, Dallas, TX.

Oct 8-11: American Academy of Family Physicians, Hilton Hotel, Atlanta. Info: R Rusken, 1740 W 92nd St, Kansas City, MO 64114.

Oct 13-18: American Academy of Pediatrics, St. Francis Hotel, San Francisco. Info: R G Frazier, MD, 1801 Hinman Ave, Evanston, IL 60204.

Oct. 22-26: American College of Surgeons (Clinical Congress), Chicago. Info: E Gerrish, MD, 55 E Erie St, Chicago, IL 60611.

Oct 25-Nov 2: American Society of Clinical Pathologists, Las Vegas, Nev.

Nov 3-4: American Association of Ophthalmology, San Francisco. Info: L A Zupan, 1100 17th St NW, Washington, DC 20036.

1980 Meeting Dates/Sites

Jan 4-11: American Society of Clinical Pathologists, San Diego, Calif.

Mar 9-13: American College of Cardiology, Houston, TX.

Hand Symposium

Third Annual John R Sebald Hand Symposium sponsored by

Bethesda Lutheran Medical Center—**St Paul, Minn**

Friday, September 28, 1979

in O'Shaughnessey Education Center at the College of St Thomas in St Paul

Featured speakers:
- *Richard Smith, MD*, Chief of Hand Surgery Services, Massachusetts General Hospital, Boston
- *Joseph Kutz, MD*, Clinical Professor of Surgery, University of Louisville, Louisville, Ky
- *Allen Van Beek, MD*, Associate Professor of Plastic and Reconstructive Surgery, University of Southern Illinois, Springfield, Ill

Application has been made for Category I credits, AMA, AAFP, and Minnesota Nurses Association continuing education credit.

Afternoon workshop for physical and occupational therapists to emphasize rehabilitation and splinting methods for diseases and deformities in the hand.

- *Diane Accurso, OTR*
- *Pat Schober, OTR*
  Bethesda Lutheran Medical Center

For information on registration contact **Tim Hanson, Associate Administrator, Bethesda Lutheran Medical Center, 559 Capitol Blvd, St Paul, Minn 55103; 612/221-2395.**

7-8/79

Nov 8-10: *Accent on Youth*—a program to familiarize the practicing physician with new frontiers of medicine in pediatrics, at the Hilton Inn in Albuquerque, New Mexico (6 hours Category 1, CME credit). Info: American Medical Women's Association, Inc, 1740 Broadway, New York, New York 10019; phone 212/586-8683.

Nov 28-Dec 2: American Medical Tennis Association, Smoke Tree Ranch, Palm Springs, Calif. Info: Bill Drake, Executive Director, PO Box 183, Alton, Ill 62002.

MIDWEST CANCER SEMINAR

September 20-22, 1979

Concourse Hotel, Madison

Program

Thursday, September 20

1:00 Moderator — *Paul P Carbone, MD*

Welcome — *Arnold L Brown, MD*

1:15 **Screening for Cancer in Clinical Practice**

Critical Concepts, *Richard R Love, MD*

High-Risk Patients, *Anthony E Camilli, MD*

Tests for Breast, Colon-Rectum, Cervical and Lung Cancer, *Richard R Love, MD*

3:30 Carcinogens in Our Environment — How Much Risk? *Henry C Pitot, MD, PhD*

4:00 Thyroid Cancer Following Head and Neck Irradiation: An Approach to Patients at Risk, *Dennis L Citrin, MD*

4:30 Post-Menopausal Estrogens — Risks and Benefits, *Delores A Buchler, MD*

Friday, Sept 21

8:30 **New Approaches to Male GU Cancer**

Moderator: *Thomas E Davis, MD*

Combination Chemotherapy for Disseminated Testicular Cancer, *Lawrence H Einhorn, MD*

Treatment of the Hormonally Unresponsive Patient With Carcinoma of the Prostate, *Ralph C Benson Jr, MD*

10:30 **Small Cell Lung Carcinoma**

Moderator: *Ernest C Borden, MD*

Results of Therapy — Small Cell Undifferentiated Lung Cancer, *Lawrence H Einhorn, MD*

Role of Radiotherapy in the Treatment of Small Cell Carcinoma of the Lung, *Joyce C Kline, MD*

1:00 **Gastrointestinal (Large Bowel and Pancreas) Cancer**

Moderator: *Hugh L Davis Jr, MD*

Surgical Management and Staging of Large Bowel Cancer, *William L Donegan, MD*

The Evolving Role of Radiotherapy in the Management of Gastrointestinal Malignancies, *Albert L Wiley Jr, MD*

Update of Current Adjuvant Studies, *Hugh L Davis Jr, MD*

2:45 **Hematologic Malignancies**

Childhood Acute Lymphocytic Leukemia — Progress and Problems, *Bruce M Camitta, MD*

Stage 1-11 Non-Hodgkin's Lymphomas: Improved Five-year Survival After Combined Radiotherapy-chemotherapy, *Gianni Bonadonna, MD*

5:00 Keynote Address: **Hodgkin's Disease**

Henry S Kaplan, MD

Saturday, Sept 22

Breast Cancer

Moderator: *Paul P Carbone, MD*

8:30 Primary Management of Breast Cancer, *William L Donegan, MD*

9:00 Adjuvant Chemotherapy in Operable Breast Cancer, *Gianni Bonadonna, MD*

9:30 Patient Selection for Hormonal Therapies, *B J Kennedy, MD*

New Developments in Cancer Therapy

10:15 New Approaches in Radiation Oncology

10:30 Interferon: Rationale For Use in Human Neoplasia, *Ernest C Borden, MD*

11:30 Priorities and Direction in Professional Education, *Nicholas G Bottiglieri, MD*

Acceptable for 12 credit hours of Category 1 of AMA-PRA

Info: Registration deadline, Sept 15, 1979. Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705. Tel: 608/263-6919.

1980 Wisconsin

Jan 3-9: 13th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics and Endocrinology*, at Pfister Hotel and Tower in Milwaukee. Six-day course extended to include a complete up-to-date review of endocrinology and cytogenetics in addition to a thorough resume of gynecological pathology. Designed primarily as a postgraduate refresher course for residents, practitioners, and specialists desiring a current review of the pathology and the reproductive tract. Guest faculty: H W Jones, MD; Georgeanna S Jones, MD; J D Woodruff, MD; and Conrad Julian, MD. Space limitation requires registration for the entire course which is limited to 150 registrants. Approved for 55 cognate hours of prescribed credit by ACOG and meets criteria for 43 hours of credit in Category 1 for the PRA-AMA. A $450 enrollment fee will include 68 selected 35mm slides. Registration fee is nonrefundable. Info: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, Medical College of Wisconsin, 8700 West Wisconsin Ave. Milwaukee, Wis 53226; phone 414/257-8200.

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News You Can Use

ALERT! A Minneapolis-based group of medical consultants known as Mobil-Exams has contracted with the Wisconsin Bureau of Social Security Disability Insurance to perform certain physical-mental examinations in Wisconsin, the results of which assist the Bureau in determining eligibility for Social Security disability benefits. This group of 2nd and 3rd year residents is reportedly used only where local specialists are unavailable to perform such exams. They sometimes seek consultant radiologic or pathologic services from local physicians. If you have questions about these consultant services, contact SMS (toll-free 800-362-9080, or in Madison area 267-6781) or Robert Cohen, Administrator, Bureau of Social Security Disability Insurance, PO Box 7623, Madison, Wis 53707 (608/266-1981).

IMMUNIZATION ACTION. "Up in the air" is the best way to describe efforts to require evidence of immunization before admission to all school grades K-12 this fall. Legal problems appear to be frustrating a departmental rule mandating the immunizations; and even a successful legislative process will delay implementation until next year. Meanwhile SMS is urging all members to voluntarily seek to get all students in all schools immunized to the proper levels this fall. SMS urges local doctors to seek the assistance of local school officials to get the job done. (See editorial, "Council acts on immunization," in this issue, page 9.) For more information contact Beth Jones or Diane Upton at SMS headquarters in Madison (toll-free 800-362-9080, or in Madison area 257-6781).

New vaccine available from Division of Health. Division of Health (DOH) is substituting combined Measles-Mumps-Rubella (M-M-R) vaccine for the Measles-Rubella (M-R) vaccine it distributes free to state physicians. This new vaccine is available for ages 15 months through six years, with the stipulation that physicians do not charge for the biologicals. The DOH will supply vaccine as long as federal support for the program continues. Physicians are urged to order the vaccine (1/2 cc dose with needle and syringe included), packed ten doses per box. Those interested should write the Division of Health, Bureau of Prevention, PO Box 309, Madison, Wis 53701, or call (608) 266-23 46. In addition, the DOH commends those physicians who: (1) have ordered biologicals regularly; (2) have begun audits of their immunization records, and (3) have established "tickler" files to notify parents when immunizations are due. According to a recent DOH survey of two-year-olds, private medicine provides about 75 percent of immunizations.

Title 18 profile information. A physician interested in obtaining a "profile" of his/her practice as recorded by either of the Title 18 (Medicare) fiscal intermediaries—WPS or Surgical Care—may do so by addressing a request in writing to: Mr Ed Helmke, Wisconsin Physicians Service, 1717 West Broadway, Madison, Wis 53713; or Surgical Care, Professional Relations—Medicare Correspondence, 401 West Michigan Avenue, Milwaukee, Wis 53201.

Medicaid Super-Rule soon—maybe. The Dept of Health and Social Services has mailed all providers in the Wisconsin Medical Assistance Program a provider bulletin to update them on the current status of the provider contract and the Super-Rule. According to the bulletin, if a physician had signed the "interim contract" for participating in the Medical Assistance Program, his or her contract is automatically renewed. Physicians should note that the "Provider Agreement" attached to the bulletin is for informational purposes only. As soon as the Super-Rule is implemented, physician providers will be sent a copy of the MD portions so they can review it prior to executing the new mini-provider agreement which is designed to meet minimal state and federal requirements. Guesstimators predict issuance of Super-Rule in about 60 days, implementative 60 days after that. The new rule is a major improvement over previous drafts primarily as a result of SMS Physicians Alliance efforts. ■

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WISCONSIN MEDICAL JOURNAL

SEPTEMBER 1979

• "Wellness" . . . in perspective • Medicine's key legislative issues summarized • ". . . as designated by the Secretary . . . " • The use of esophageal manometry in children • Healthcare in the 80s conference October 12 at Delavan • SMS/WAFP seminar for physicians October 31 at Wisconsin Rapids

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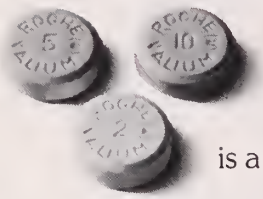

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President's Page

Darold A Treffert, MD

"WELLNESS" . . . . . In Perspective

THE YELLOW EMPEROR, in the year 4978 BW (Before Wellness), also spoke of prevention, wholism, risk appraisal, and prospective medicine albeit in his terminology:

> "Sages here do not treat those who are already ill, they rather instruct those who are not yet ill. The really talented physician helps before the early budding of disease. The inferior physician begins to help when the disease has already developed. He helps when destruction has already set in. The skillful doctor treats those who are well, but the inferior doctor treats those only who are ill. The good doctor pays constant attention to keeping people well so that there will be no sickness. The able doctor acts before sickness comes."

Our colleague, Louis Pasteur, focused on prevention as well: "When meditating over a disease, I never think of finding a remedy for it, but instead, a means of preventing it."

Why there was even concern before our concern about the special health problems of women. John Waitgrove, in a before-its-time affirmative action feminist treatise entitled *Practical Observations for the Prevention and Cure of Chronic Diseases Peculiar to Women* lamented:

> "The poor female cottager who uses exercise in the open air: who eats the coarse wholesome bread of her own industry, and drinks from the cooling stream, is seldom troubled with those maladies that affect the rich and indolent; undone by the abuse of plenty."

So wellness, valuable as it is, is not all that new or novel. Hence, as physicians, we should need only to be reminded of that which has, through common sense and wisdom, been known all along rather than indoctrinated with slogans as if something new has been discovered, and as if all else must be discarded.

A second useful perspective, it seems to me, in our welcome resurgence of interest in wellness, rather than an exclusive preoccupation with illness, is that in terms of concern about health, there is a hazard in two directions. Surely a society that eats too much, drinks too much, smokes too much, and pollutes too much; that exercises too little, brushes too infrequently, and buckles up not often enough; ingests the wrong food, injects the wrong substances and inhales the wrong particles; crowds too closely together, lives at too quick a pace and does not often enough kick its shoes off, lay back and close its eyes—surely that society runs an extraordinarily high collective risk appraisal profile. Sensibility, moderation, and common sense ought to apply. In short, we need to cool it and live more sensibly and sanely. So living too carelessly is a hazard.

But to be overly concerned, preoccupied even, with health, germs, dirt, cholesterol, cardiac output, resting pulse, saturated and unsaturated lipids, plaques (dental and arterial), running when one could walk or walking when one could rest—those concerns, if taken at a fetish or fad level, threaten to create a sanitary, sterile, prophylactic, almost spartan lifestyle devoid of joy, spontanaity and even any risk at all. That's a hazard also, in the other direction. An anonymous fellow, reflecting late in his life, writes about the other hazard of health concern—too much of a good thing:

> "If I had my life to live over again, I'd try to make more mistakes next time. I would be sillier than I have been this trip. I would relax. I would limber up. I know very few things I would take seriously. I would be crazier. I would be less hygienic. I would climb more mountains, swim more rivers, and watch more sunsets. I would eat more ice-cream and less beans. I would have more actual troubles and

fewer imaginary ones. You see, I am one of the people who live prophylactically and sensibly and sanely, hour after hour, day after day. Oh, I have my mad moments, and if I had it to do over again, I'd just have more of them. In fact, I'd try to have nothing else. Just moments, one after another, instead of living so many years ahead. I have been one of those people who never go anywhere without a thermometer, a hot water bottle, a gargle, a raincoat, and a parachute. If I had it to do over again, I would go places and travel lighter than I have."

"If I had my life to live over again, I would start barefooted earlier in the Spring, and stay that way later in the Fall. I would play hookey more. I would ride merry-go-rounds. I'd pick more daisies."

Wellness is a welcome emphasis. But if it is to remain creditable, which it must if it is to survive, it must be based on facts and data, rather than slogans and beliefs. We must not confuse our hopes and aspirations with reality, and present those hopes and aspirations as if they were reality. Other factors—heredity, constitution, and perhaps even a generous portion of serendipity—difficult as they are to measure in risk appraisal, all help determine health or illness. When we can factor out with clarity the specific risk of each of the various factors contributing to health or illness, then we can present those with vigor and enthusiasm, even Evangelism, and still have the movement retain its credibility.

Sigmund Freud once said of psychoanalysis that for some people it is like handing a starving man a menu. Likewise, the wellness movement must have substance, rather than merely suggestions or possibilities, if it is to maintain its momentum and replace society's fascination with illness with a new fascination about health. What we do not need is a set of new wives' tales to simply add to the lore of already too many old wives' tales. ■

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

Time to Join Arnie's Army

DOES ARNOLD PALMER NEED golf lessons from FTC? Should FTC scrub at Alton Ochsner's surgery? FTC says "yes."

Palmer, speaking for the United States Golf Association on national television, says FTC is out of bounds when it charges USGA's voluntarily developed rules for amateur and professional golf are in restraint of trade. He says FTC itself wants to set golf club standards, write the rules of play, and certify the various opens.

Physicians can sympathize with Palmer's outrage. They have seen FTC's determined attacks on their associations. Hopefully this latest FTeeC shot will slice into Arnie's following crowd and produce a call to Congress for penalty strokes (curbing FTC's budget) or disqualification (limiting FTC's jurisdiction). In any event, Arnie's Army looks like a good bet to keep FTC on the fair-way.—ERT

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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As a service to its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference!

A brochure, "Alcohol and Your Unborn Baby" (in English and Spanish versions), published by the State Medical Society of Wisconsin for physicians and patients now is available in quanity by writing to:

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Letters

Coronary artery bypass surgery

I READ WITH INTEREST the papers concerning coronary artery disease which appeared in the August issue of the *Wisconsin Medical Journal.* The reports of the surgical results of a rather small study suffer from the same deficit as do the majority of these papers in that it is not a double-blind, randomized trial. When one is using actuarial statistics, while quite interesting, these may not have a direct relationship between cause and effect.

I do believe the weight of evidence is becoming greater that coronary artery surgery does prolong life, but this is not yet a scientific fact. There is no question that there is a great improvement in the quality of life for those people who had angina before successful surgery.

Hopefully, a scientific answer to this question will be obtained at the close of the Coronary Artery Surgery Study, which is anticipated in the next two to three years.

RICHARD D SAUTTER, MD
Marshfield, Wisconsin

Maternal mortality

I APPRECIATE DR KLOSTER'S response to my article, "Maternal Mortality, Yesterday, Today and Tomorrow," which was published in the *Wisconsin Medical Journal* (April 1979). I am happy to know that he is concerned about maternal mortality and the fact that efforts must be made to continue these studies. I am pleased to learn that he is concerned about the unwed mother and her infant who might become the victim of circumstances ultimately causing problems for the child.

My interest in this area dates back to my origin in medicine when I served an internship in the Salvation Army Home for unwed mothers. At the Home, the unwed mother received medical care, education, counseling and rehabilitation. All mothers must be taught to instruct their children to protect themselves from pregnancy. Young patients must be informed of their obligations.

In conjunction with maternal mortality studies, it is essential that there be studies which also concern the health of infants; perinatal and neonatal studies. In addition, I am a firm believer in helping youth learn the proper approach to sex, sexual activity and personal protection. Sex education is necessary. One must not overlook the welfare and health of an expectant mother and an infant in utero during delivery and also during the immediate postpartum period. Our Country can be proud of the care rendered to mothers and infants but excellence of care and counseling must continue and be upgraded.

I wish to emphasize that Dr Kloster should be cognizant of the fact that I have a wide angle lens resulting in a wide view of the entire situation rather than the tunnel vision which is his accusation and assumption.

My goal is not merely counseling. The goal which I have set for myself and the organizations with which I am associated has been to make available the best possible education in family planning to all. This must begin, not with the adolescent or the teenager, but with the premarital advice given to young people who are about to become married. They must be advised in great sincerity to love the infant which will be forth coming from the embryo as a result of fertilization after marriage. That love and attitude must grow throughout the antenatal period, through the perinatal period and through the life of the child. There must be appropriate education and counseling of both parents and the adolescent concerning understanding sex, pregnancy and prevention of

The Editors would like to encourage physicians to contribute to the LETTERS TO THE EDITOR section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

pregnancy. I believe that pregnancy should be prevented when not desired. I do not believe there should be deliberate destruction and killing instead of prevention. I do, however, firmly believe where there is risk to mother as a result of her physical status and the existence of pregnancy, under such circumstances, in a very small number of pregnancies, abortion is a feasible method of therapy. This, however, should be done with adequate and dependable consultation. A baby born out of wedlock should not be thought of as an object that should be neglected, destroyed and not taken care of but as a valuable individual to be loved. Some of these children that I have known have grown into Obstetricians and Gynecologists; Nurses doing High Risk, Special Care Nursing; Theologians; Business people. They were loved in the environment of their single parent's home. Where this was not possible, they were raised in the environment of adoptive parents.

Education is essential and efforts to control are essential. Efforts to destroy must be minimized, and therefore, where pregnancy exists, it is essential that maternal mortality be continuously studied to salvage mother and hopefully, these studies should be continued with investigation of perinatal morbidity and perinatal mortality. All must be reduced to a minimum. Healthy Babies and Healthy Mothers must be the answer.

I hope I have clarified my position, I will continue, not only in the State of Wisconsin but on a national scale, and make every effort for continuing communication between maternal and perinatal mortality and morbidity study committees a practical reality. The goal is to have all states and other countries speak the same type of language and make every effort to keep this program, which has helped so many, going and growing.

F J Hofmeister, MD, FACOG
Past President, The American College of Obstetricians and Gynecologists and The Central Association of Obstetricians and Gnyecologists
Wauwatosa, Wisconsin

Other activities include: Chairman, Midwest Conference of Maternal Mortality Study Committees; Vice Chairman, Maternal Mortality Study Committee, State of Wisconsin; Chairman, Special Interest Group on Maternal Mortality, The American College of Obstetricians and Gynecologists.

Physician's Assistant

I received the April issue of WMJ and the May 3 issue of NEJM (*New England Journal of Medicine*) in the same mail delivery. After reading Doctor Dougherty's appeal for increased usage of physician's assistants, I turned to "Coping With the Approaching Doctor Glut" in the NEJM. Doctor Louria reports a ratio of one physician per 735 people in 1950 and projects a "mind-boggling" one per 347 between the years 1990 and 2000. "By 2020, there may be one physician for every 250 to 300 people."

I am confused. If (the statement), "It has been suggested that 80% of everyday office problems can adequately be handled by a PA working under the supervision of a physician.", has any degree of validity as stated by Doctor Dougherty and we actively encourage the growth of this group, what are all the MDs and DOs to do?

Daniel P Collins, MD
West Allis, Wisconsin

WMJ help

When i learned last year that the costs of publishing the WMJ were discussed with a view towards ceasing its publication, I was unhappy. This Journal has provided an outlet for many Wisconsin authors, and I think it is most important for all of us to help keep this fine publication going strong. For that reason, I am quite happy to provide whatever additional subsidy is needed for publishing the lengthy Doctors Afield.

Dean M Connors, MD
Madison, Wisconsin

Editor's Note: We thank Doctor Connors for his kind remarks and his willingness to help subsidize publication costs. Since institution of the WMJ policy which allows authors or other sources to help subsidize publication costs of articles, the WMJ has been very gratified with favorable responses, and the above letter is most typical.

Life Membership

I was most interested in the article in the April *Wisconsin Medical Journal* of Dr Andrew L Banyai of his acknowledgment of his receipt of the plaque of Life Membership in the State Medical Society of Wisconsin.

It seems so few doctors in the state society appreciate and consider the honor the plaque represents. As I read the caption and the underlying statements, I was touched and honored to be numbered as one of the many doctors to have served and I believe faithfully in the meritorious service to the cause of humanity. To me, my 56 years of medical service does not seem that long.

In looking at the plaque before me, I see the signature of secretary Earl Thayer. I will always cherish the privilege of my association with him in the many affairs of the State Society. I have always respected his high principles and complete knowledge of the affairs and traditions as secretary of the society. This association will be cherished for as long as I live.

I have served in a number of official capacities during my 56-year membership and George and Charlie Crownhart and Earl Thayer have been and are the very best.

GUY CARLSON, MD
Appleton, Wisconsin

Spontaneous rupture of the biceps

IN THE MARCH ISSUE of the *Wisconsin Medical Journal,* Doctors Babbitt, Sty and Kohler describe the spontaneous rupture of the biceps in a 6-year-old boy suffering from rheumatoid arthritis. I have seen the rupture of the biceps femoris in a 30-year-old sprinter in Latvia some 40 years ago. At the start of the sprint in an athletic competition, he suddenly felt an acute pain in the left knee and was unable to run.

The next day, he visited me in my Riga office. There was a large bluish discoloration in the popliteal fossa and in active bending of the knee the biceps tendon could not be seen and felt. The young man was admitted to the Latvian Red Cross Hospital in Riga where I sutured the ruptured tendon. No postoperative complications and he left the hospital.

Later, he was again able to participate in athletic events and did not have any discomfort. During the war, which swept three times over my unfortunate country, I lost him and never met him again.

R PAVASARS, MD
Appleton, Wisconsin

Living With Cancer program

THE AMERICAN CANCER SOCIETY has recently established a self-help program in Dane County entitled "Living With Cancer." The purpose of the Living With Cancer program is to provide psychological and emotional support to cancer patients and their families.

In the form of one-to-one home visits, cancer patients and/or their families are brought together with others who have had similar concerns as a result of the disease. The concern of the volunteer visitor is to provide emotional support and encouragement, and *not* to provide medical information or facilitate medical comparisons.

If you know of anyone who would benefit from a home visit, please contact the Dane Unit of the American Cancer Society, Wisconsin Division, at 249-0210, and a visit will be arranged. There also are posters and information sheets available for use in your office or institution.

If you know of any patients or family members who have successfully adjusted to their cancer experience who might be interested in participating as volunteer visitors in this program, please put them in contact with us.

We are confident this program will be a positive value to cancer patients and their families, and your cooperation will be most welcome.

DOLORES A BUCHLER, MD
Medical Advisor
CONNIE SMOCZYK
Volunteer Coordinator
American Cancer Society
Wisconsin Division Dane Unit
609 North Sherman Ave
PO Box 1626
Madison, Wisconsin 53701

MEDICAL EXAMINING BOARD

The Wisconsin Medical Examining Board has revoked the medical license of Marvin L Stern, MD, Cypress, California, because of actions by California and Nevada medical examining boards revoking his license for violating laws relating to the regulation of narcotics, dangerous drugs, and controlled substances.

The Board has stayed proceedings in the matter of the license of Nathaniel O Calloway, MD, Madison, until Doctor Calloway's health permits him to return to practice or to participate in defense before the Board.

Richard Eckberg, MD, Stevens Point, has been appointed to the Medical Examining Board. Doctor Eckberg's appointment awaits Senate confirmation.

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Governmental Affairs

Medicine's key legislative issues summarized

THE WISCONSIN STATE LEGISLATURE returns to regular floor sessions for one month beginning on October 2, 1979. This floor period is the third in the scheduled five floor periods for the 1979-80 session. The first two floor periods, which ran from January to July with a break for committee work, was dominated by consideration of the 1979-81 biennial budget bill.

Since July 1, many of the committees of both the Senate and Assembly have been busy conducting public hearings and developing recommendations on a large number of the bills introduced thus far in the session. Health committees in both houses have received testimony from SMS representatives on a wide range of issues, including access to healthcare records, immunization programs, catastrophic insurance plans, minimum health insurance benefits, prohibitions on charges for completing insurance forms, a series of medical liability proposals, and others.

The October floor period will be a busy one for SMS in that the very first day of the session—October 2—will see Senate consideration of Senate Bill 30, a proposal to mandate chiropractic coverage in all health insurance policies sold in Wisconsin. This issue, one which has been a concern of the Society for many sessions, has had a difficult history. In the last sitting of the Legislature, a veto by then Governor Martin Schreiber prevented its enactment; a veto sustained by the Senate by a vote of 17-15.

The following is a listing of the key bills followed by the SMS Physicians Alliance in this session. This summary includes a brief description of the bill and its current status, as well as the Society position as determined by either the Commission on Governmental Affairs or the Physicians Alliance Commission. Questions regarding these or any other legislative proposals may be directed to the Physicians Alliance, P.O. Box 1109, Madison; or by calling toll-free 1-800-362-9080. Updates are provided via the SMS MEDIGRAM or the weekly legislative update CAPITOL WEEK.

* * *

SB 29—Mandatory Insurance Coverage for Psychologists. This bill, introduced by the Senate Human Services Committee, would mandate all insurers and cooperative associations to provide coverage for services rendered by a psychologist. This bill would also allow diagnostic and therapeutic services to be provided by psychologists, without physician supervision or referral. The State Medical Society and the Physicians Alliance have opposed in principle any mandated health insurance legislation. Mandated health insurance coverage only adds to the spiraling costs of health care. In particular, question has been raised regarding outpatient services included in this legislation. The legislation implies that medications will be allowed to be furnished by a psychologist to a patient without supervision or referral from a physician at a hospital or outpatient treatment facility. There has been no further action on SB 29. The Assembly Health & Social Services Committee recommended passage with amendment an identical bill, AB 67, which is now in the Joint Finance Committee.

SB 30—Mandatory Insurance Coverage for Chiropractors. This bill, introduced by the Senate Insuance and Utilities Committee, would mandate all insurers who offer health or disability insurance to cover chiropractor services. Life insurers must accept chiropractors' certification regarding disability. The bill would also mandate coverage of chiropractic services by "anv contract, plan, policy or program established, provided, issued or delivered in the state on an individual, franchise, group or blanket basis." This mandate would also include prepaid health insurance plans and cooperatives. SMS feels that all the people of Wisconsin should not be required to pay insurance premiums for the small minority of people who use chiropractic services. SB 30 was referred to the Joint Finance Committee where it received, on an 8-5 vote, a recommendation for indefinite postponement. Senate floor action is scheduled for October 2.

SB 80—Regulation of Smoking. Introduced by two Madison legislators, Senator Fred Risser and Representative Mary Lou Munts, this proposal prohibits smoking in public places and conveyances, except in designated smoking areas. Places covered by the act include government buildings, educational facilities, inpatient health care facilities, offices, public waiting rooms, restaurants and retail establishments. Places

Prepared by Brian Jensen, Director
SMS Physicians Alliance Division

exempted are restaurants with 50 or less seating capacity, taverns and banquet rooms. Known as "Wisconsin's Clean Indoor Air Bill". SB 80 is not anti-smoker; considerations are offered to the smoker and nonsmoker alike. It is designed to provide a smoke-free area for those who choose it while at the same time designating areas for those who wish to pursue their habit. Considering the legislation a step in the right direction in attacking the number one preventable health hazard, the Medical Society has expressed its support. It does remain, however, a quite controversial issue in the legislative halls and could take a different shape in the amendment process. The Senate Human Services Committee reported the bill out with a favorable recommendation and it is now in the Joint Finance Committee.

SB 163—Minor's Consent for Alcohol and Drug Abuse Treatment. SB 163 would permit minors 12 years of age or older to consent to outpatient counseling for diagnosis and treatment of alcohol and other drug abuse under limited circumstances. Parents are not required to be notified during the first 72 hours of inpatient treatment and detoxification. The first 6 outpatient counseling sessions for the purpose of diagnosis and assessment of alcohol and other drug abuse will be exempt from parental notification. The first 60 days of outpatient counseling for the purpose of alcohol and other drug abuse treatment will also be exempt. School counselors may confidentially refer minors to treatment. The intent of SB 163 is to allow minors to seek counseling for the abuse of alcohol and other drugs before the minor's physical condition deteriorates to the point where it can no longer be hidden from parents. Present state law only allows for treatment of minors for venereal disease without parental consent. SB 163 was introduced by the Human Services Committee which has recommended its passage. It will be referred to the Joint Finance Committee shortly. All provisions of SB 163 have been incorporated into SB 19 which is Senator Cullen's 19-year-old drinking bill. (That bill is presently in Joint Finance.) The Medical Society's Committee on Alcoholism and Other Drug Abuse has recommended Society support for this legislation. There are 12 states which presently do not require parental consent for any form of treatment. Two additional states, Iowa and Kentucky, do not require parental consent for alcohol and drug abuse treatment.

SB 181—Determination of Death. SB 181 provides that legal and medical death is an irreversible cessation of all functioning of the brain. The use of other usual and customary criteria to determine death is also allowed. Several states have passed similar brain death legislation to date. Language in the bill was developed by the Special Legislative Council Committee on the Definition of Death. Representation on the Committee included persons from legal, medical, religious and legislative fields. SB 181 was introduced by the Legislative Council which has the most influential legislators among its membership. The Medical Society is in support of this measure. A public hearing was held on the bill in May at which the State Medical Society presented testimony. The Human Services Committee has taken no further action.

AB 107 & AB 279—Marijuana and THC for Medical Purposes. Two similar proposals are before the Assembly Health & Social Services Committee which will allow glaucoma and cancer chemotherapy patients to use marijuana or THC for therapeutic purposes. Both bills set up Boards which review patient applications, submitted by physicians, for purposes of certifying patients to participate in the program. The Board in AB 107, introduced by Representative Ronald Lingren (D-Menomonee Falls), is composed of an ophthalmologist, a psychiatrist and an oncologist. In AB 279, introduced by Representative David Clarenbach (D-Madison), a pharmacist would be appointed to the Board in addition to the three physicians. The only other difference is the Clarenbach bill would allow the use of locally confiscated marijuana. Rep. Clarenbach has recently introduced an amendment to AB 279, however, which would delete the use of locally confiscated marijuana, but instead would allow the Wisconsin Department of Agriculture to cultivate it for use. Either method would require federal approval since the Controlled Substances Act allows only the federal government to distribute marijuana or THC, and then only for research purposes. Both bills are designated the "Controlled Substances Therapeutic Research Program." The State Medical Society took a position in opposition to AB 107 but took no direct position on AB 279. SMS does not oppose the concept of therapeutic use of marijuana but feels that the date and information obtained by research being conducted by other states and agencies is transferrable. In Wisconsin there already is a mechanism through the research permit procedure of the Controlled Substances Board for persons to carry out valid research with marijuana and THC and a whole new panel and bureaucracy which would be part of AB 107 is unnecessary.

AB 243—Charging Fee for Completion of Insurance Forms. AB 243 prohibits any person from charging an extra fee for any service rendered in connection with the completion of any health or disability insurance claim form. Any person who violates the provisions created by this bill is subject to a civil forfeiture in the amount of $100 for each violation. The Governmental Affairs Commission agrees with the AMA policy statement which states "The attending physician should complete without charge the appropriate 'simplified' health insurance claim form and similar claim forms as a part of his or her service to the patient to enable the patient to receive his or her benefits. A charge for more complex forms may be made in conformity with local customs." The Senate Insurance & Utilities Committee took the following executive action on the bill on June 19: AM 1, permitting charging fee for copying costs, adoption recommended 5-0; AM 2, clarifying that forms for patients to receive benefits be completed

without charge, adoption recommended 4-0. Committee recommended passage 3-0.

AB 326 & 327—Statute of Limitations in Malpractice Actions. AB 326 and 327 establish a discovery rule in malpractice cases. Under AB 326, introduced by Representative James Rutkowski (D-Hales Corners), legal action must be initiated within 3 years of occurrence of the alleged injury or 1 year from the date it was discovered. No action may be initiated more than 6 years after the date of occurrence or, in the case of a minor, age 10, whichever is later. AB 327, introduced by Representative Dismas Becker (D-Milwaukee), would add a "discovery clause" to the Statute of Limitations and permit a malpractice action to be brought within 3 years after an individual becomes aware of the injury or reasonably should have been aware of the injury. The Medical Society is strongly opposed to AB 327. There is speculation that if the Legislature does not take action on a "discovery rule," the courts will impose some sort of discovery rule. Present law allows actions to be brought 3 years from the date of occurrence or, in the case of a minor, age 10, whichever is later. Hearings have been held on both bills in the Assembly Judiciary Committee. AB 326 has been reported out with a favorable recommendation and was referred to the Joint Finance Committee.

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AB 637—Expert Medical Witnesses. AB 637, introduced by Representative Ed McClain (D-Wausau) at the request of the Physicians Alliance, specifies that expert witnesses in medical malpractice actions must be licensed and practicing in Wisconsin or a contiguous state and must show satisfactory experience, training and knowledge relating to the subject at issue in the case. The purpose of AB 637 is to eliminate the use of professional "traveling witnesses" who make a living by testifying in malpractice actions. Organizations such as the technical Advisory Service for Lawyers, based in Phoenix, Arizona and Malpractice Research, Inc, from Virginia are examples of groups who provide witnesses throughout the country. This legislation would prevent these organizations from being effective in Wisconsin by assuring that Wisconsin experience and local norms would be taken into consideration when determining standards of care and extent of liability. The Assembly Judiciary Committee heard testimony on AB 637 but no further action will be taken until September.

AB 655—Inadmissibility of Formal Patients Compensation Panel Findings. AB 655, introduced by Representative Michael Ferrall (D-Racine) also at the urging of the Wisconsin Academy of Trial Lawyers, is strongly opposed by the Physicians Alliance. Under present law, if a malpractice suit is filed for less than $10,000, the issue automatically goes to an informal Panel where its findings are inadmissible in circuit court if the Panel decision is appealed. If a malpractice suit is filed for more than $10,000, the case automatically goes to a formal Panel where the findings are admissible in a court of law if the Panel decision is appealed. The State Medical Society feels that:

1. The Patients Compensation Panels were created to serve as an alternative to the court system in resolving malpractice claims. AB 655 would render the Panels a mere prerequisite to court action;
2. The Panels have been very effective in resolving malpractice actions in that 14 of every 15 cases are settled at the Panel level and never have to enter the court system;
3. Panels have been cost effective to Wisconsin taxpayers because the Panels are supported solely by fees paid by health care providers. The courts require the use of tax dollars to function and court actions can be both costly and lengthy;
4. Admissibility of formal Panel findings in court actions was a major component of the 1975 debate on malpractice legislation. Physicians, attorneys and legislators, after active discussion, agreed upon the need for admissibility in a court of law: and
5. Legally accepted rules of evidence are followed by the formal Panels and thus Panel findings should be admissible in a court of law. ■

In Perspective

BRIAN JENSEN, Director
Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

". . . as designated by the Secretary . . ."

THE RECENT DEPARTURE of HEW Secretary Joe Califano in the Carter Cabinet shakeup brings to mind the immense authority which is delegated to that official by both the President and the US Congress. Califano incurred the wrath of both White House staff and members of Congress because of his attitude of independence and arrogance in the promotion of programs and policies within the scope of the massive department. While I would be the last one to defend the actions of Mr Califano, both the Presidential Staff and Congress have conveniently forgotten that they in large part created the animal which they ultimately decided must be offered as a sacrifice.

The State Medical Society of Wisconsin has for several years utilized a group of nine physicians to review in depth dozens of federal proposals which impact upon the practice of medicine. This "Committee on Federal Legislation," chaired by Dr Robert Purtell, Jr of Milwaukee, spends hours and hours each month reviewing not only congressional proposals but also proposed regulations of a host of federal agencies including the Department of Health, Education, and Welfare. The work of the Committee is intensive, difficult and . . . frustrating. The job of analyzing federal proposals is much more difficult than state legislation in that the distance from Washington precludes much direct contact with members of Congress, and the political rhetoric connected with legislative suggestions increases in direct proportion with the status of the elected officials.

However, one common characteristic of both state and federal legislative bodies is the willingness of each to delegate authority to the bureaucracy responsible for the implementation of its legislative ideas. One seldom needs to read beyond the second or third page of any federal health proposal before encountering a delegation of authority to the bureaucracy and a charge to the agency head to develop standards, criteria, implementation guidelines, and most importantly, an interpretation of legislative intent. Virtually every major health proposal "passes the buck" (in spite of the President's admiration for Harry Truman's famous desk sign) to the executive agency. Hence, the actual implementation of programs is then accomplished in a manner "designated by the Secretary."

Most health-related proposals of the Congress are massive in and of themselves. Any attempt at analysis involves hours and hours of research, debate, and comparison to existing laws. State laws are no different. The Wisconsin Medical Assistance Program, for example, is outlined in about 20 pages of the *Wisconsin Statutes*. Rules designed to implement and enforce that program in addition to interpreting legislative intent appear in over 300 pages of the infamous "Super-Rule." In addition, hundreds of pages of provider bulletins, handbooks, billing manuals, etc are needed to administer the program. All of these, of course, are developed by an administrative agency and include standards and guidelines designed by department employees to insure the proper expenditures of some $700 million per year in Wisconsin alone.

Few legislators seem to appreciate this delegation of authority. Fewer still are inclined to spend the time necessary to review rules and regulations for a consistency with the legislative intent embodied in a legislative bill. The situation at the federal level is no different. Legislators agree that they are unable to spend the time necessary to develop standards and that the true purpose of the agency (the "executive" branch) is to implement laws. However, these same legislators decry the growth of the government, demand legislative "oversight" of agency decisions, and demand Mr Califano's head.

This inconsistency also brings to mind another frustration encountered by the Federal Legislation Committee and the staff assigned to it. Legislators demand input from health professionals not from the standpoint of philosophical arguments for or against a particular proposal, but prefer detailed recommendations regarding amendments to legislation down to the placement of periods, commas, and semicolons. The SMS

committee has been very diligent in responding in this fashion, providing letters and testimony which detail every concern. The response from legislators? "Thanks very much for your letter . . . I'll keep your comments in mind" . . . which is a way of saying "I've filed your letter and maybe I'll read it."

I for one cannot believe that our US Senators and Congressmen, as active as most of them are in healthcare matters, truly expect our committee to believe that as legislators they are without a position on healthcare planning, hospital cost containment, or Medicaid/Medicare fraud and abuse proposals. Senator Nelson certainly has been in the forefront of the national debate over hospital cost containment, yet he thus far has been unable or unwilling to respond to the very constructive and realistic suggestions of the medical profession.

Perhaps the easiest way for elected officials to restore the confidence in government that they perceive is lacking among their constituents is to move away from "passing the buck" to the Secretary and begin to assume a position of increased responsibility for their actions.

Until that responsibility is faced by Congress, until legislative bodies recognize all the ramifications of their activities and participate in the implementation of their programs, we may be faced with a continuation of the policy of regular offerings of a sacrificial lamb to the public. After all, Harry Truman *also* said, "If you can't convince them, confuse them."—BRIAN JENSEN ■

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with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.

Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting, impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoontul syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults.* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

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Scientific Medicine

REFER TO: Werlin SL, Dodds WJ, Hogan WJ, and Arndorfer RC: The use of esophageal manometry in children. *Wisconsin Med J* 78:25-27 (Sept) 1979

KEY WORDS: Esophageal manometry, hiatal hernia, Sandifer's syndrome, childhood gastroesophageal reflux

The use of esophageal manometry in children

Steven L Werlin, MD; Wylie J Dodds, MD; Walter J Hogan, MD; and **Ronald C Arndorfer**
Milwaukee, Wisconsin

● **We present four children in whom the use of esophageal manometry and intraluminal pH monitoring was helpful in the medical management of their illnesses. The child with unexplained recurrent vomiting, recurrent respiratory infections, or dysphagia may benefit from evaluation by esophageal manometry in addition to barium radiological examination.**

RECENT TECHNOLOGICAL advances have led to a greater understanding of both the physiology and pathophysiology of esophageal motor function. These technological advances, however, have not been widely applied to the pediatric patient. Investigations of esophageal motor function can be of great assistance in the diagnosis of gastroesophageal reflux (GER) and its complications, *eg* recurrent emesis, aspiration, and Sandifer's syndrome as well as for investigating abnormalities of esophageal motor function associated with dysphagia.[1,2] This report concerns four children admitted to Milwaukee Children's Hospital during a four-month period in 1978, in whom the use of esophageal manometry and intraluminal pH monitoring either established or confirmed the diagnosis of esophageal motor dysfunction.

From the Departments of Pediatrics, Radiology, and Medicine, The Medical College of Wisconsin; and the Department of Pediatrics, Division of Gastroenterology, Milwaukee Children's Hospital; and the Departments of Radiology and Medicine, Division of Gastroenterology, Milwaukee County Medical Complex, Milwaukee, Wisconsin. Supported in part by United States Public Health Services Grant AM 15540. Publication support provided. Reprint requests to: Steven L Werlin, MD, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wis 53233. Copyright 1979 by the State Medical Society of Wisconsin.

METHODS. All esophageal manometric studies were performed in the Gastrointestinal Motility Laboratory at Milwaukee County Medical Complex staffed by personnel trained in performing esophageal studies. The instrumentation and recording techniques have been described previously[3,4] with the exception that a nine lumen manometric assembly (4.5 mm in outer diameter) with a central hollow core is now used. A 1.5 mm micro electrode pH probe is inserted through the central lumen and exits the assembly through a side hole 3.5 cm above a distally located sleeve device which is used to monitor lower esophageal sphincter (LES) pressure. The sleeve device, 4 cm in length, straddles the LES and records LES pressure continually despite the axial movement of the sphincter with swallowing and respiration. The sleeve method is particularly important in monitoring LES pressure in children because the manometry tube does not have to be moved once the distal high pressure zone is located and this greatly enhances patient cooperation.

Complete evaluation of esophageal motor function can be accomplished at a single sitting with the passage of a single tube. The manometric study with pH monitoring takes less than one

hour to do and can be done as an outpatient examination. Most infants and children require no sedation. In those that are restless, intravenous diazepam is administered to light sedation.

ILLUSTRATIVE CASES. Case 1. A six-week-old girl was referred to the Milwaukee Children's Hospital for recurrent emesis since birth and failure to thrive. An upper gastrointestinal series showed no evidence of GER or gastric outlet obstruction. Esophageal manometry revealed normal peristalsis and LES pressure (Fig 1). Despite normal LES pressure, GER could be repeatedly induced by raising the infant's legs while she was supine, as shown by a drop in intraluminal esophageal pH recorded by the intraluminal electrode. The infant was treated with thickened feedings and upright positioning. Her vomiting promptly stopped and she gained weight rapidly.

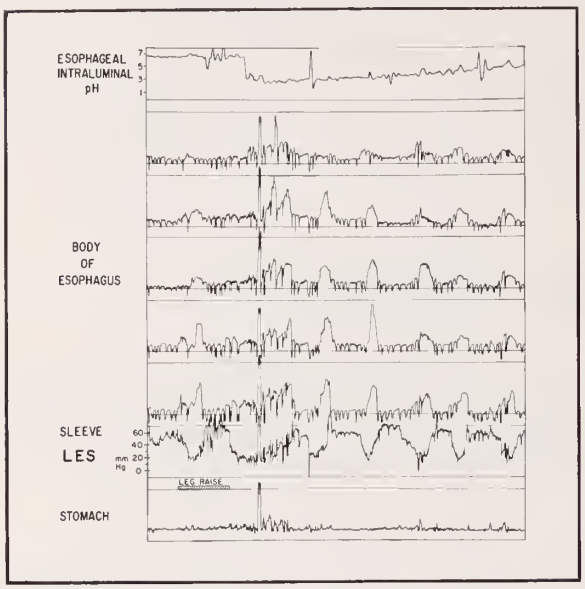

FIGURE 1—Case 1. Note normal peristaltic wave moving from proximal to distal. Basal LES pressure is 50 mm Hg. Note fall in esophageal intraluminal pH associated with leg raising.

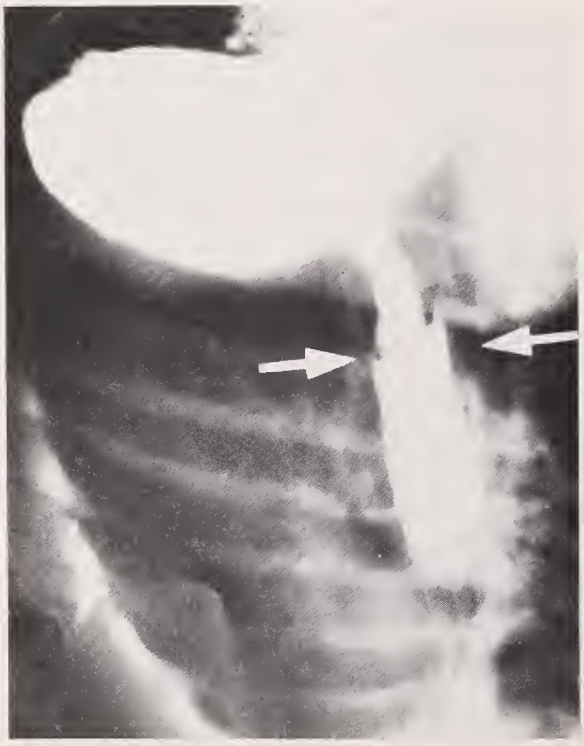

FIGURE 2—Hiatal hernia. Arrow marks the supradiaphragmatic portion of the hiatal hernia.

Comment. Although GER, commonly called chalasia, was suspected clinically, it was not documented by barium x-ray study nor was it reflected by a low LES pressure. The diagnosis, however, was confirmed by intraluminal pH monitoring. Interestingly, GER occurred frequently despite a normal resting LES pressure. Esophageal manometric studies and pH monitoring should be considered in all children such as this infant with persistent emesis to search for GER as well as to evaluate esophageal motor function.

Case 2. A four-day-old girl was hospitalized for repeated emesis. An upper gastrointestinal series revealed GER and a large hiatal hernia (Fig 2). In addition to a very low LES pressure, esophageal manometrics demonstrated aperistalsis of the esophageal body and the presence of GER as documented by a fall in intraluminal pH (Fig 3). The patient was treated with upright positioning and thickened feeding (half formula, half cereal). Over a period of three weeks vomiting decreased and weight gain was established. At five months of age she is now thriving.

Comment. Neonates with hiatal hernia and reflux may fail to respond to medical management and require an operation. Since there is no information available on the long-term prognosis of infants with both hiatal hernia and esophageal motor dysfunction, we believed that surgical intervention was unwarranted. Therefore, medical therapy was continued despite its initial failure. An operation was avoided because of the eventual success of medical management. Thus, esophageal manometric examination of this child provided information which helped avoid an operative procedure.

Case 3. A 16-day-old girl was hospitalized for seizure-like activity. Neurological examination was normal. During hospitalization it was noted that she had frequent bouts of emesis. An upper gastrointestinal series was normal. Esophageal manometry and pH monitoring demonstrated spontaneous GER occurring even during sleep. She was treated with antireflux measures, and no further episodes of seizure-like activity were seen.

Comment. Sandifer's syndrome is an unusual combination of seizure-like activity, abnormal positioning or torticollis associated with GER.[5,6] Infants and young children presenting with such symptoms should be evaluated for GER so that appropriate therapy can be instituted. Anticonvulsant therapy invariably fails to control the seizure-like symptoms.

Case 4. A five-month-old boy was hospitalized

for recurrent pneumonia. The first episode of pneumonia developed at age three weeks. Evaluation, including sweat chloride and serum immunoglobulins, was normal. Barium swallow revealed diminished esophageal peristalsis, but no evidence of GER. GER was not demonstrated by esophageal pH measurement but manometry showed complete absence of peristalsis (Fig 4). Further history revealed that the mother, who was 17 years old and unmarried, frequently fed the child in a prone position and then put him into the crib. She was instructed to feed the child upright and maintain him in this position.

Comment. Infants and young children with recurrent pneumonia or wheezing have been increasingly shown to have esophageal motor dysfunction, either aperistalsis and/or GER.[2,7] In this case, the lack of primary peristalsis is thought to be the major problem. In infants, the mechanism of the pulmonary disease is probably recurrent aspiration. Children with recurrent pneumonia should be evaluated for the possibility of esophageal motor dysfunction.

DISCUSSION. Esophageal manometry and intraluminal pH monitoring are safe and well tolerated procedures in children. We have now performed more than 40 such studies in infants and children (ages 5 days to 13 years) without significant untoward effects. Most children require little or no sedation and many fall asleep during the procedure. The sleeve assembly positioned at a single station has markedly enhanced patient cooperation and compliance.

The patients described above were admitted to the Milwaukee Children's Hospital during a recent four-month interval. Only one (Case 2) had symptoms directly attributable to esophageal motor dysfunction, yet all were shown to have significant dysfunction of the LES, esophageal body or both.

We believe that esophageal function tests are helpful in elucidating the etiology of a variety of symptom complexes in infants and children and should be performed in addition to barium radiological evaluation in patients with suspected disorder of esophageal function. Esophageal motility studies are most helpful in evaluating children with unexplained recurrent vomiting, recurrent respiratory infections and dysphagia.

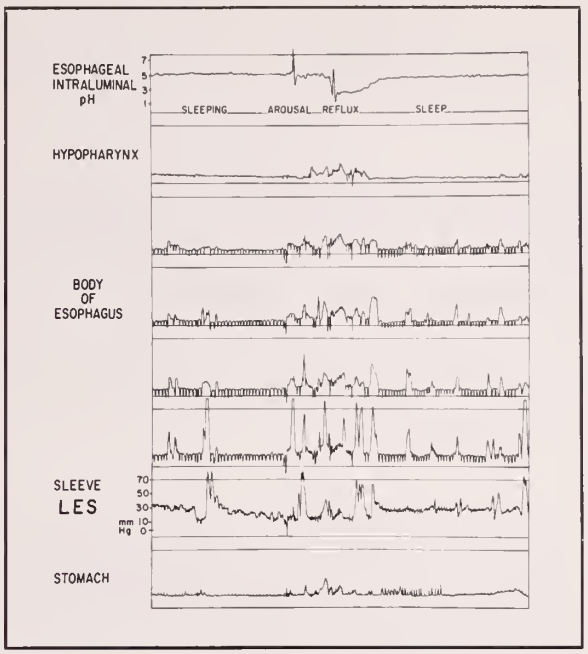

FIGURE 3—Case 2. Note lack of peristalsis in esophageal body. With arousal from sleep intraluminal pH spontaneously fell from the basal level of 5 to 2.

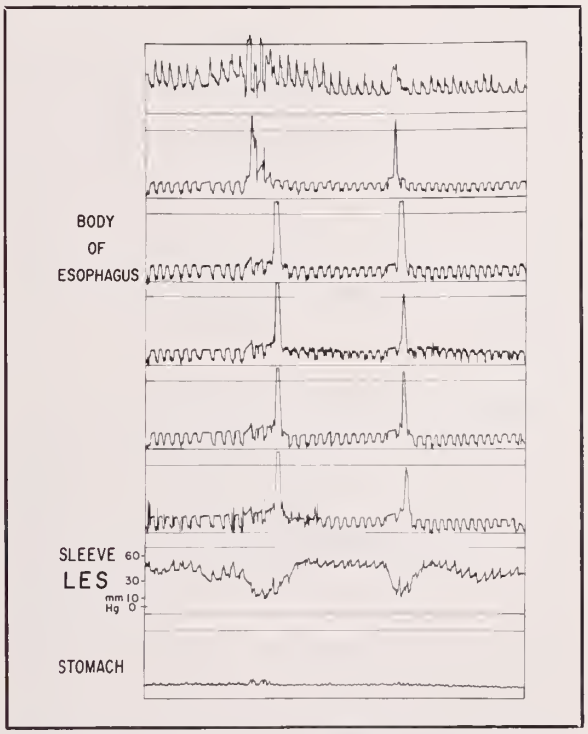

FIGURE 4—Case 4. Note absence of peristalsis in esophageal body. All contractions are simultaneous. The LES relaxes normally.

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REFER TO: Carrera GF, Mascatello VJ, Holm HH, Berger M, and Smith EH: Ultrasonically guided percutaneous biopsy of gastric lesions. *Wisconsin Med J* 78:28-29 (Sept) 1979

KEY WORDS: Ultrasound imaging, gastric lesions, percutaneous biopsy

Ultrasonically guided percutaneous biopsy of gastric lesions

Guillermo F Carrera, MD; V J Mascatello, MD; H H Holm, MD; M Berger, MD; and E H Smith, MD
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● **In a recent series of cases the demonstration of circumferential gastric antral disease proved to be easy and reliable. One of the patients studied was clinically unable to undergo gastroscopy, or to permit adequate evaluation by upper gastrointestinal series. Ultrasound examination revealed characteristic findings of a gastric wall lesion, and percutaneous biopsy was carried out under ultrasound guidance. Cytologic examination of the aspirate revealed adenocarcinoma. The patient improved enough later in her hospital course to allow confirmation by endoscopy and mucosal biopsy.**

ULTRASOUND IMAGING (gray-scale and bistable) has become a widely accepted diagnostic technique for evaluating abdominal and retroperitoneal disorders. Aspiration biopsy of abdominal and retroperitoneal mass lesions has also been successful under ultrasonic guidance.[1,2,3,4] Our recent experience, using ultrasound to diagnose gastric wall abnormality,[5] prompted us to attempt percutaneous biopsy in a patient whose clinical condition made endoscopy difficult.

CASE DESCRIPTION AND METHOD. A 73-year-old woman was admitted to the Peter Bent Brigham Hospital from her nursing home residence for evaluation of progressive weakness and anemia. The patient was blind and mildly demented; she had coexisting medical problems including diabetes mellitus, Paget's disease of bone, severe peripheral vascular disease, and mild congestive heart failure. Physical examination revealed an epigastric mass. Initial laboratory evaluation showed a moderate hypochromic normocytic anemia, and normal liver function and coagulation studies. Barium study of the upper gastrointestinal tract suggested a mass in the gastric antrum, but was decidedly suboptimal because of the patient's poor condition and poor cooperation. Ultrasound examination of the abdomen revealed a characteristic, relatively sonolucent epigastric mass with dense internal ("ring-sign") Fig 1.[5,6]

Because of the patient's poor condition the decision was made to attempt percutaneous biopsy of the mass with ultrasonic guidance. Following the procedure described by Smith et al[3] the lesion was scanned under sterile conditions using a special biopsy transducer.*[4] Depth markers were projected over the ultrasound image (Fig 2). The skin was infiltrated with 1% lidocaine and the biopsy transducer stabilized directly over the lesion. Following insertion of a 19-gauge "introducing" needle through the skin, a 23-gauge aspiration needle attached to a syringe was directed into the mass to the preselected depth. Aspiration was performed as the needle was agitated several times over a 1-2 cm vertical path, then withdrawn. The aspirate was immediately smeared and fixed for cytologic examination. Several aspirations were done. The patient returned to the ward for post-biopsy observation.

RESULTS. Cytologic examination of the aspirated material was diagnostic of adenocarcinoma, probably of gastric origin. The patient experienced no complications or side effects from the biopsy. Her clinical status improved sufficiently to allow endoscopy at which time the diagnosis of adenocarcinoma of the stomach was confirmed both visually and by mucosal biopsy.

DISCUSSION. Percutaneous biopsy under ultrasound guidance is a safe, reliable, and relatively easy diagnostic modality for a variety of lesions. This case illustrates the usefulness of this technique in a patient with a suspected gastric lesion who is unable to cooperate with endoscopy. Since no sedation and relatively little cooperation is necessary for a rapid and safe biopsy under ultra-

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*Aerotech Laboratory, Lewiston, Pa.

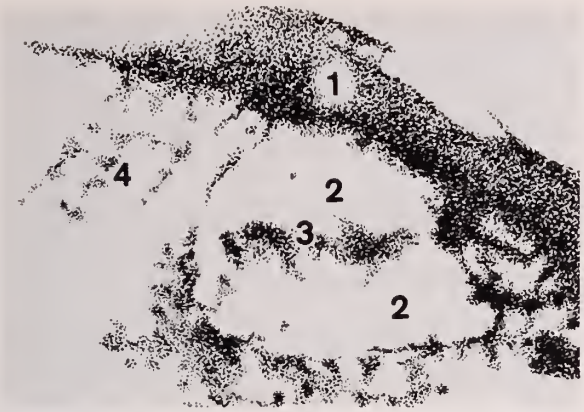

FIGURE 1—Schematic representation of the "ring-sign"[5] of gastric antral thickening. 1. Anterior abdominal wall, 2. Sonolucent "ring" representing the gastric wall lesion, 3. Dense central collection of echos representing intraluminal gastric contents including air, 4. Liver.

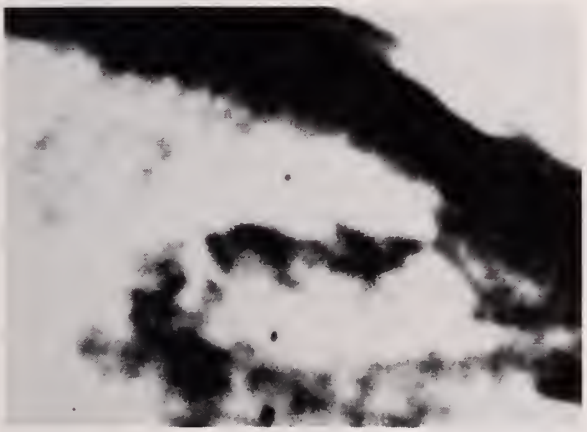

FIGURE 2—Longitudinal section in the mid-line showing the characteristic "ring-sign" of gastric antral thickening. 1-cm depth markers are projected over the image in preparation for biopsy.

sound guidance, it is an attractive technique especially in the difficult patient for whom tissue diagnosis is required for treatment planning. The constellation of a characteristic "ring sign" of gastric abnormality and cytologic evaluation of the aspirate should provide accurate, minimally invasive evaluation of gastric masses. This technique offers promise for evaluation of intramural gastric lesions especially in cases where endoscopic findings and endoscopically controlled biopsy may be negative.

ADDENDUM. Since the preparation of this manuscript, we have encountered a second patient with an abdominal mass and characteristic ultrasound findings. Percutaneous biopsy revealed adenocarcinoma, proven surgically to be metastatic to gastric wall from a small pancreatic primary. The overlying gastric mucosa was intact.

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Abstracts

Effect of oral contraceptives on plasma androgenic steroids and their precursors

FERN, MARGARET; ROSE, DAVID P; FERN, EDWARD B, (Wisconsin Clinical Cancer Center, University of Wisconsin, Madison, Wis): *Obstet-Gynec* 51(5):541-544, 1978.

Measurement of plasma androgenic steroids has been suggested as a practical way to identify women with increased risk of developing breast and possibly endometrial cancer. Women (18-35 years of age who had been taking oral contraceptives for at least six months) were given estrogen containing contraceptives (Ovral®, Demulen®, or Ortho-Novum®). All three contraceptive preparations caused a reduction in plasma dehydroepiandrosterone, its sulfate ester, androstenedione, Δ^5-pregnenolone, and 17α-hydroxypregnenolone. Plasma Δ^5-pregnenolone concentrations correlated well with those of dehydroepiandrosterone, suggesting that the effect of contraceptive steroids on the synthesis of C_{19} steroids occurs prior to the synthesis of Δ^5-pregnenolone since the rate-limiting step in the conversion of cholesterol to the secretory products of the adrenal cortex is the biosynthesis of Δ^5-pregnenolone. An alternative explanation would be that the reduction of C_{21} and C_{19} adrenal androgens is secondary to a diminution in ACTH stimulation of the adrenal cortex. It has been observed that breast cancer patients and apparently healthy women who subsequently develop the disease have a subnormal excretion of urinary 11-deoxy-17-ketosteroids and plasma dehydroepiandrosterone sulfate. The results of this study suggest that the use of oral contraceptives would invalidate the measurement of plasma androgenic steroids to identify women with increased risk of developing breast cancer and perhaps endometrial cancer. ■

REFER TO: Johnson LW and Ciccantelli MJ: A noninvasive approach to the diagnosis of pheochromocytoma. *Wisconsin Med J* 78:30-31 (Sept) 1979

KEY WORDS: Pheochromocytoma, computerized tomography, arteriography

A noninvasive approach to the diagnosis of pheochromocytoma

Lane W Johnson, MD and **Mark J Ciccantelli, MD,** Milwaukee, Wisconsin

TRADITIONALLY THE DIAGNOSIS of pheochromocytoma has rested upon historical factors, appropriate laboratory tests, and tumor localization through arteriography.[1,2] The development of body scanning now provides a noninvasive means of tumor localization. We report a case of pheochromocytoma with tumor localization by computerized tomography (CT) scan and arteriography.

From the Department of Family Practice, Medical College of Wisconsin, Milwaukee, Wisconsin. Reprint requests to: Lane W Johnson, MD, Department of Family Practice, Medical College of Wisconsin, 610 North 19th St, Milwaukee, Wis 53233. Copyright 1979 by the State Medical Society of Wisconsin.

Case report. A 71-year-old normotensive white female presented with a 20-year history of occasional attacks of chest pain, tachycardia, diaphoresis, and dizziness. She had been hospitalized on three occasions for possible "heart attacks." The patient also had a 10-year history of diabetes mellitus controlled

FIGURE 1—Abdominal aortogram raising the question of a poorly defined vascular lesion at the upper pole of the left kidney.

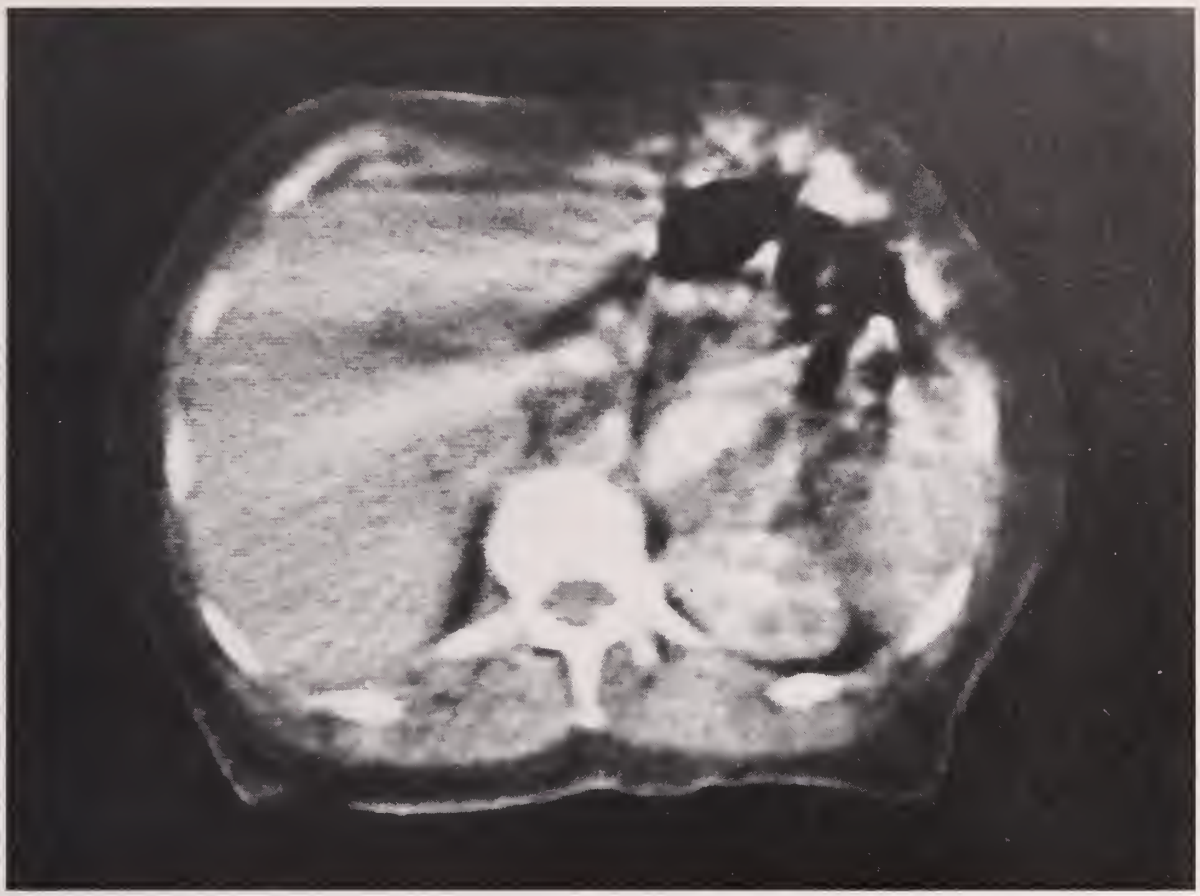

FIGURE 2—A computerized tomographic section at the level of the kidney showing a large solid mass anteriorly and abutting the left kidney (note diamond-shaped marker).

with oral hypoglycemics. Two days after a routine examination the patient developed an "attack" of chest pains, tachycardia, and diaphoresis. Electrocardiographic changes were consistent with anteroseptal ischemia and the patient was admitted to the coronary care unit. The patient was mildly hypertensive at the time of admission. While in the intensive care unit the patient developed another "attack." Her blood pressure at that time was 260/130 mm Hg. Blood pressure returned to normal within 30 minutes without treatment.

Physical examination was unremarkable except for mild exogenous obesity and a thyroid nodule. Significant laboratory studies showed the following: 24-hour urine catecholamines 1,794 ug/ml (normal: 100), metanephrine total 4.2 ug/24-hour (normal: 0.3-0.9), 24-hour VMA 22 mg/100 ml (normal: 10), serum calcitonin 10 pg/ml (normal: 200). Selective renal arteriography is shown in Figure 1. A body CT scan is shown in Figure 2.

Blood pressure was kept at normotensive levels with a combination of alpha- and beta-blockade. At laparotomy, a 4.6 cm tumor was removed from the superior pole of the left kidney. Histopathologic examination confirmed a well encapsulated pheochromocytoma.

The patient's postoperative course was unremarkable. Twenty-four hour urine catecholamines were 130 ug/ml at discharge.

Comment. This case is significant in several aspects. The patient presented with a 20-year history of "heart attacks" necessitating hospitalization on three occasions, yet the diagnosis was never entertained. More significantly, body CT scan proved a valuable noninvasive diagnostic tool. Stewart and associates[3] have recently reported a 91% accuracy rate with CT scans in patients with proven pheochromocytoma. Stewart points out, however, that CT scans are most accurate for tumors over 2 cm in diameter. The tumor in this patient was 4.6 cm. Finally, the patient responded well to a regimen of alpha- and beta-blockade, both preoperatively and during surgery.[4,5]

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REFER TO: Samadani AM: A newborn infant with congenital varicella. *Wisconsin Med J* 78:32 (Sept) 1979
KEY WORDS: Congenital varicella

CASE REPORT

A newborn infant with congenital varicella

Ayaz M Samadani, MD
Beaver Dam, Wisconsin

CHICKEN POX VIRUS in early pregnancy may cause congenital anomalies in the infant. This report describes a newborn female, with skin manifestations, whose mother had contracted varicella 14 days prior to delivery.

Case Report. A 29-year-old white female, para II, gravida III, contracted varicella in the ninth month of her pregnancy. The pregnancy up to that time had been uneventful. She developed a fulminating rash 14 days prior to onset of labor. Her clinical course was complicated with late stage of rash. Her labor was without any complications and she delivered vaginally a live female infant. The baby weighed 7 lb 6 oz and measured 20 inches in length. APGAR was 8 and 10.

The infant was normal except for the rash on the skin. The rash was maximal on the trunk with few lesions on the hands and legs. It was papulo-vesicular surrounded with large areas of erythema. There were no pustules. The next day fresh crops of rash appeared on the chest wall.

The rash of the mother and baby cleared on the third postpartum day.

Laboratory studies of the mother were all within normal range except for a white blood cell count elevated to 11,700 per cu mm. Rubella antibodies were reported as "protective."

Laboratory returns for the infant were: Varicella antibodies immune fluorescent titre against V2 virus was 1:16 on the second day and 1:8 two weeks later. Immune globulin: IgG 1440/ul (normal 200-700); IgA $<$57 (normal 10-60); IgM $<$80 (normal 10-80). Phenylketonuria: negative. Bilirubin: 8.8 mg/100 ml (direct: 1.4; indirect: 7.4). Hemoglobin level: 20 gm/100 ml. Hematocrit reading: 57.5 vol%. White blood cell count: 20,000 per cu mm with a normal differential count.

The infant and mother were kept in the same room. They recovered and were discharged home without any complications. ■

Reprint requests to: Ayaz M Samadani, MD, 130 Warren St, Suite 213, Beaver Dam, Wis 53916 (Phone: 414/887-7731). Copyright 1979 by the State Medical Society of Wisconsin.

Abstracts

Carcinogenic and mutagenic activities of milk from cows fed bracken fern

(*Pteridium aquilinum*)

PAMUKCU, A MAHIR; ERTÜRK, ERDOGAN; YALCINER, SENAY; MILLI, UMIT; BRYAN, GEORGE T (Department of Human Oncology, University of Wisconsin Center for Health Sciences, Madison, Wisconsin and Department of Pathological Anatomy, College of Veterinary Medicine, University of Ankara, Turkey). *Cancer Research* 38: 1556-1560, 1978.

Bracken fern is used as a food delicacy and salad green in many parts of the world, but it is also a forage contaminant in certain areas. Its consumption has been correlated with an increased incidence of esophageal carcinoma in humans in certain regions of Japan. As a forage contaminant, bracken fern has caused bladder carcinoma in cows and water buffalo and intestinal and bladder carcinoma in sheep in Yugoslavia, Bulgaria, Turkey, and Columbia. Cows, rats, mice, guinea pigs, and Japanese quail fed bracken fern develop a wide variety of bladder, intestinal, and other neoplastic lesions.

The human cancer hazard from bracken fern may not be restricted to direct consumption of bracken fern, since milk from cows fed bracken fern contains a carcinogen which causes bladder and intestinal carcinoma in rats and a mutagen for *Salmonella typhimurium* TA 100. Humans, therefore, may be exposed to the bracken fern carcinogen by consuming milk and dairy products prepared from the milk of cows which graze on bracken fern. ■

REFER TO: Zachman RD: Increasing usefulness to the white blood count in neonates. *Wisconsin Med J* 78:33-34 (Sept) 1979
KEY WORDS: Neonatal sepsis, neonatal bacterial infection, neonatal blood counts

Perinatology

Editor: LUIS B CURET, MD
Professor, Department of Obstetrics and Gynecology
University of Wisconsin Center for Health Sciences
Madison General Hospital, Madison, Wisconsin

Increasing usefulness of the white blood count in neonates

Richard D Zachman, MD, PhD
Madison, Wisconsin

EDITORIAL NOTE: The diagnosis of neonatal sepsis has always been fraught with the problem of confirmatory laboratory evidence. Although it has customarily been thought that blood counts are not useful in the neonate, recent evidence tends to indicate that this simple laboratory test may be very useful. The following article reviews normal and abnormal blood counts during the neonatal period.

MANY PHYSICIANS have had to face the dilemma of diagnosing sepsis or bacterial infection in the neonate. This is a serious neonatal diagnosis, one we cannot afford to miss. Until recently, most of our training has fostered the idea that the white blood count was quite variable in the neonate, therefore it was probably not useful in helping make the diagnosis of sepsis or bacterial infection. However, newer information is shedding a different light on this old problem.

In 1970, studies reporting leukocyte blood counts of *healthy* full-term and premature babies during the neonatal period were published.[1] Of special relation to later data were the values for the neutrophil and metamyelocytic counts that peaked at 12-24 hours (Term: 8,500-19,000 neutrophils, 200-1,400 metas. Preterm: 4,000-11,000 neutrophils, 300-2,200 metas), and then decreased rapidly toward the usual counts found at a few days of age.

According to two papers published in 1972 the blood leukocyte picture in ill newborn infants with bacterial infection can follow three possible trends[2,3]: (a) an increase in absolute values of polymorphonuclear neutrophils, (b) an increase in the absolute values of immature neutrophils [bands or metamyelocytes], or (c) a neutropenia.

Another paper in 1974[4] showed that nine term newborn infants with bacterial infections had normal neutrophil counts on days one to five, but the *band* counts increased significantly beyond the normal range ($>2,000/mm^3$). The authors suggested the need for each laboratory to establish its own set of standard values from normal newborn infants.

Similar observations were soon made in premature infants. The blood leukocyte count was studied in premature infants in the presence of positive blood cultures.[5] *Band* neutrophil counts were elevated most frequently in this septic group (15 cases). Thrombocytopenia also occurred frequently.

In specific cases of Group B beta-hemolytic streptococcal sepsis presenting as respiratory distress soon after birth, absolute leukopenia ($<7,500/mm^3$) or neutropenia ($<4,000/mm^3$) was taken as a valuable indicator for the identification of early sepsis.[6,7]

The most recent study published[8] found that newborn infants dying with bacterial infection often demonstrated leukopenia, neutropenia, and thrombocytopenia. *Nonfatal* sepsis frequently had a *neutrophilia* with an increase in absolute band counts.

Finally, a study involving 304 normal neonates and 885 babies with maternal, intrapartum or neonatal complications, with 3,461 total complete blood counts cautions us. The authors found that some perinatal factors other than bacterial disease such as maternal hypertension or maternal fever prior to delivery, significantly altered neonatal neutrophil dynamics.[9]

In summary:

(a) The neonatal white blood count can be helpful in supporting the diagnosis of neonatal sepsis.
(b) Neutrophils and band counts usually *peak* in *healthy* neonates at 12-24 hours.
(c) A neutropenia or leukopenia is common in severe sepsis, including Group B beta-hemolytic streptococcal sepsis presenting with respiratory distress.
(d) A band count outside of normal is likely to be significant.
(e) Other perinatal factors might alter neonatal neutrophil dynamics.

From the Department of Pediatrics, University of Wisconsin Medical School, Madison. Publication support provided by the Wisconsin Perinatal Center, Southcentral Region, Madison. Reprint requests to: Wisconsin Perinatal Center, Southcentral Region, 202 South Park St, Madison, Wis 53715. Copyright 1979 by the State Medical Society of Wisconsin.

Also, let's remember that your clinical impression and other criteria must be effectively used in making this serious diagnosis.

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Abstracts

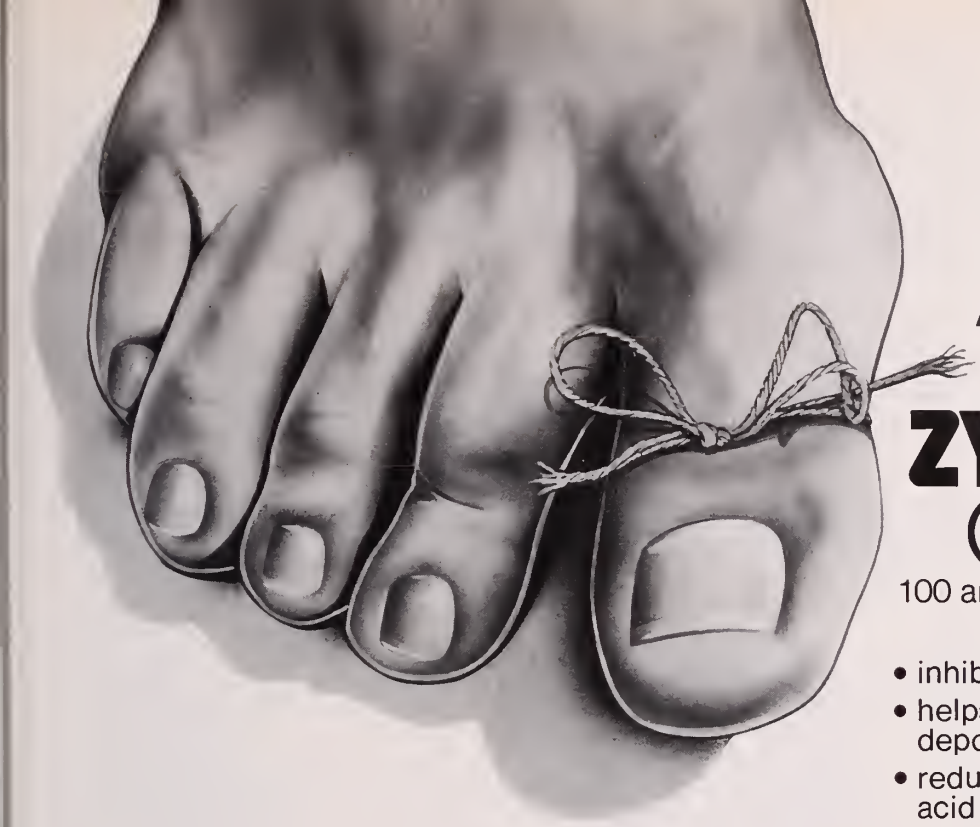
A quantitative approach to determining disease response during therapy using multiple biologic markers. Application to carcinoma of the breast

Woo, Kwang B; Waalkes, T Phillip; Ahmann, David L; Tormey, Douglass C*; Gehrke, Charles W; Oliverio, Vincent T (*Wisconsin Clinical Cancer Center).
Cancer 41(5):1685-1703, 1978.

A mathematical model was developed to quantitatively evaluate tumor response utilizing multiple biological markers obtained during the treatment of patients with malignant disease. The biologic markers measured in patients with breast carcinoma were: three urinary polyamines (putrescine, spermidine, and spermine), three urinary nucleosides (pseudouridine; N^2,N^2dimethylguanosine; and 1-methylinosine), and plasma carcino-embryonic antigen (CEA). The distribution patterns of these markers were measured before treatment and five weeks after the initiation of chemotherapy in the patients. The clinical response of the patients was classified as stable or showing progression or regression. Ratios of the pretreatment and post-treatment levels of spermine/putrescine; spermine/spermidine; spermidine /putrescine; N^2,N^2-dimethylguanosine/pseudouridine; 1-methylinosine/pseudouridine; and 1-methylinosine / N^2,N^2-dimethylguanosine were also calculated. Pretreatment CEA levels were elevated in 76% of the patients, the three nucleosides in 35.5-37.1%, spermidine in 27%, spermine in 24%, putrescine in 6.5%, and the polyamine and nucleoside ratios in 10-20%. At least one marker abnormality was observed in 79% of the patients.

The distribution patterns of marker levels were generally consistent with differences in the clinical response of the patient to treatment. Levels of CEA, N^2,N^2-dimethylguanosine, spermine/spermidine, and spermidine/putrescine were significantly higher than normal and increased in proportion to the increase in the amount of disease. Nucleoside levels were generally in better agreement with disease response than the polyamines, but the polyamine ratios were better than the nucleoside ratios. CEA combined with nucleosides and polyamine ratios may monitor disease course more effectively than CEA combined with polyamines and/or nucleoside ratios. The correlations of N^2,N^2-dimethylguanosine/pseudouridine; N,$^2N^2$-dimethylguanosine; N^2,N^2-dimethylguanosine change with treatment/pseudouridine change with treatment; spermine change with treatment/spermidine change with treatment; N^2,N^2-dimethylguanosine change with treatment; 1-methylinosine change with treatment/N^2,N^2-dimethylguanosine change with treatment; 1-methylinosine, and 1-methylinosine/pseudouridine with disease status were significant.

A multiple regression equation using the 14 marker measurements and 12 ratios was developed to evaluate the treatment results; its multiple regression correlation coefficient ($R=0.891$) was about 2.4 times higher than the most sensitive single marker variable, N^2,N^2-dimethylguanosine/pseudouridine alone. Stepwise regression analysis showed that 15 was the minimum number of multiple marker measurements and ratios needed to achieve the maximum sensitivity for detecting metastases and monitoring the course of the disease during treatment. The regression equation showed reasonably good correlation between marker variables and the disease response of patients and characterized the nature of the therapeutic response fairly well, although the quantitative accuracy of the method is limited. ■



A reminder

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Zyloprim® (allopurinol) is intended for:

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4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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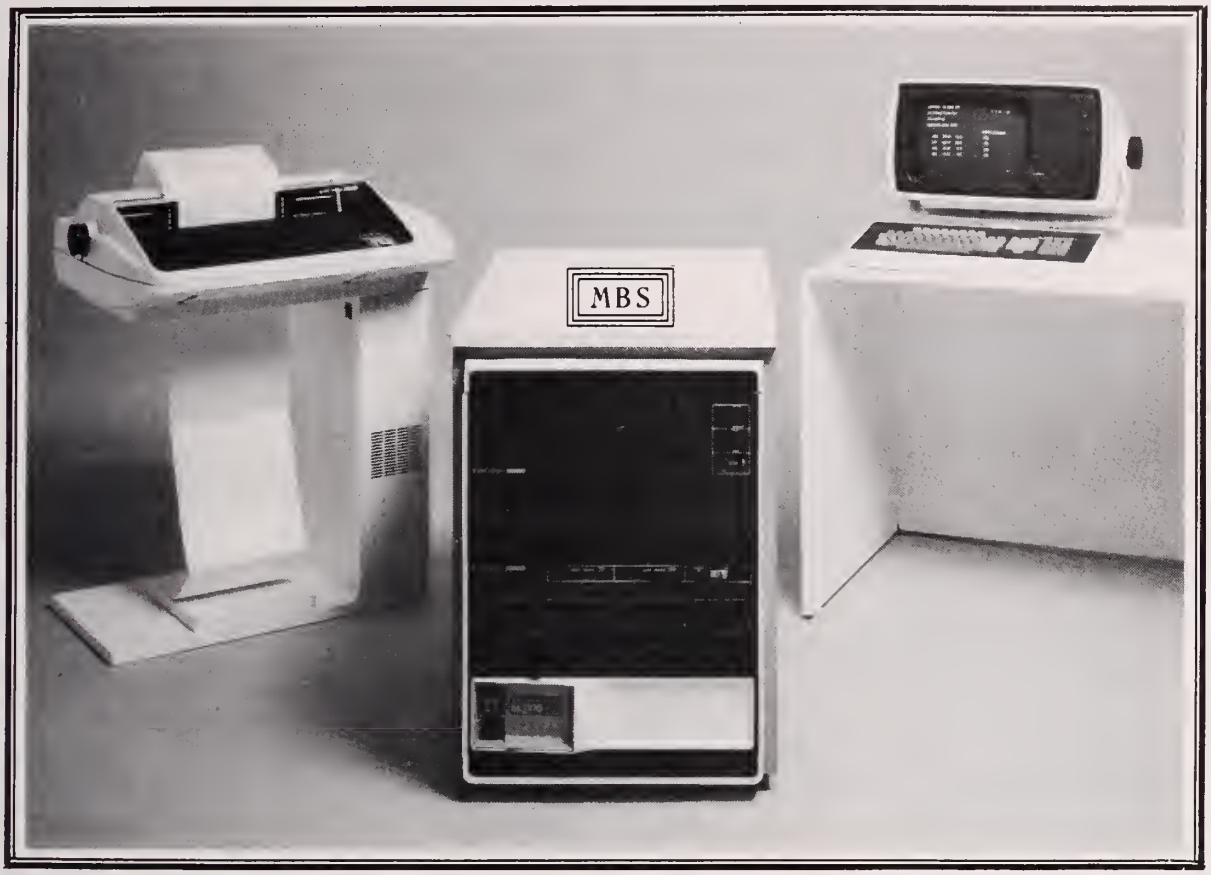

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INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below
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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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For prescribing information see opposite page.

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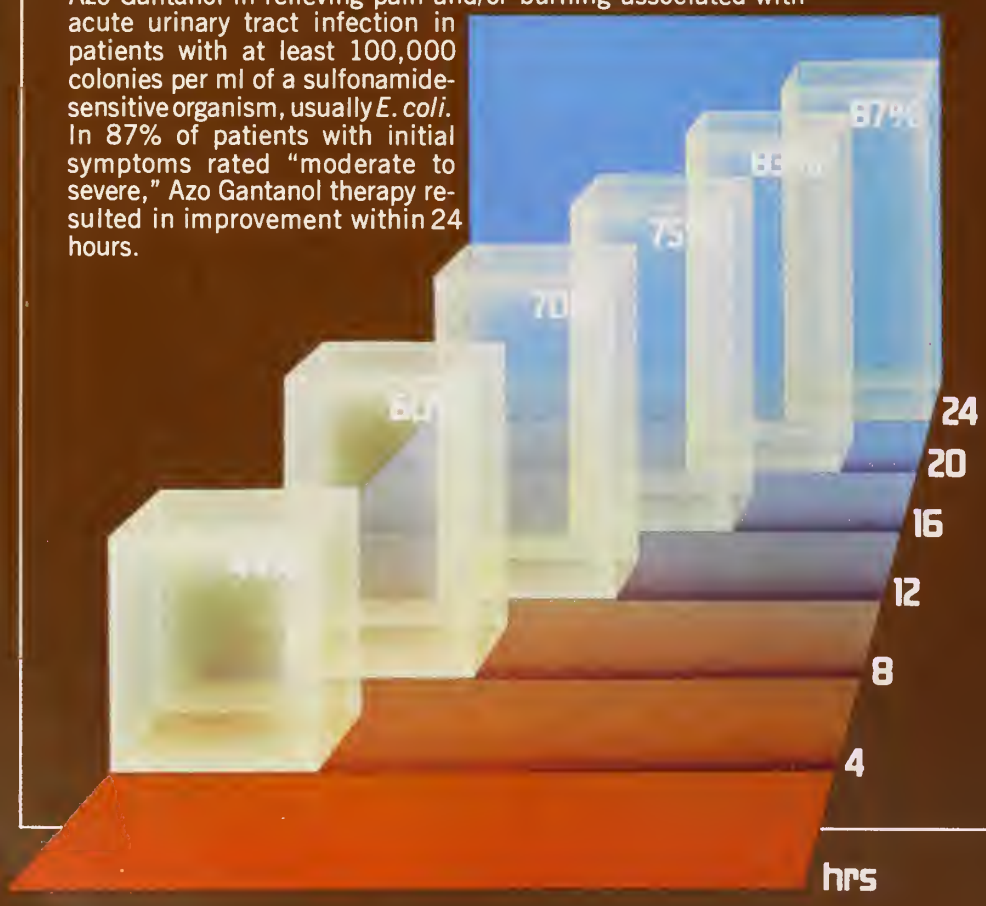

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Indications: In adults, urinary tract infectio complicated by pain (primarily pyelonephrit pyelitis and cystitis) due to susceptible orga (usually *E. coli, Klebsiella-Aerobacter, Stap coccus aureus, Proteus mirabilis,* and, less quently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note fully coordinate *in vitro* sulfonamide sensiti tests with bacteriologic and clinical respons aminobenzoic acid to follow-up culture mec increasing frequency of resistant organisms the usefulness of antibacterials including s fonamides.** Measure sulfonamide blood leve variations may occur; 20 mg/100 ml should maximum total level.

Contraindications: Children below age 12; s fonamide hypersensitivity; pregnancy at ter during nursing period; because Azo Gantan tains phenazopyridine hydrochloride it is co dicated in glomerulonephritis, severe hepat uremia, and pyelonephritis of pregnancy wi disturbances.

Warnings: Safety during pregnancy not esta Deaths from hypersensitivity reactions, agra tosis, aplastic anemia and other blood dysc have been reported and early clinical signs throat, fever, pallor, purpura or jaundice) m dicate serious blood disorders. Frequent CB urinalysis with microscopic examination are ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with paired renal or hepatic function, severe alle bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in who dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria stone formation.

Adverse Reactions: *Blood dyscrasias* (agran ulocytosis, aplastic anemia, thrombocytope leukopenia, hemolytic anemia, purpura, hy thrombinemia and methemoglobinemia); *al reactions* (erythema multiforme, skin erupt Stevens-Johnson syndrome, epidermal nec urticaria, serum sickness, pruritus, exfoliat dermatitis, anaphylactoid reactions, periort edema, conjunctival and scleral injection, sensitization, arthralgia and allergic myocar *G.I. reactions* (nausea, emesis, abdominal hepatitis, diarrhea, anorexia, pancreatitis a stomatitis); *CNS reactions* (headache, peri neuritis, mental depression, convulsions, a hallucinations, tinnitus, vertigo and insomn *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, periarte nodosa and L. E. phenomenon). Due to cer chemical similarities with some goitrogens, uretics (acetazolamide, thiazides) and oral glycemic agents, sulfonamides have caused instances of goiter production, diuresis and glycemia. Cross-sensitivity with these agent exist.

Dosage: Azo Gantanol is intended for the a painful phase of urinary tract infections. Us *adult dosage:* 2 Gm (4 tabs) initially, then (2 tabs) B.I.D. for up to 3 days. If pain pers causes other than infection should be sougl After relief of pain has been obtained, cont treatment with Gantanol (sulfamethoxazole) be considered.

NOTE: Patients should be told that the oran dye (phenazopyridine HCl) will color the uri

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

An approach to primary malignancies in bone

THE RARITY OF PRIMARY malignancies in bone prevents any one individual in primary care medicine from accumulating a broad base of experience. This article offers the approach used at the University of Wisconsin Center for Health Sciences for management of primary bone tumors from presentation through biopsy and treatment.

Malignant bone tumors usually present in one of two ways, depending upon the age of the patient and whether the tumor is primary or metastatic.

(1) Some present as a *fracture* through a lesion which has weakened the bone insidiously. In the older adult multiple myeloma or metastatic carcinoma should be suspected. A bone scan will confirm the presence of multiple lesions and allow selection of the easiest lesion to biopsy.

(2) A common presentation in the juvenile patient is *pain and swelling* in a long bone, frequently near the knee joint. Occasionally there is a history of minor trauma which draws attention to the tumor. A fixed soft tissue mass overlying a destructive bony lesion suggests a primary bone malignancy, such as osteosarcoma or Ewing's sarcoma.

The x-ray film yields information regarding the biologic activity and provides diagnostic clues about the tumor. *Growth characteristics* include size, demarcation, cortical involvement, and periosteal reaction. Small, solitary, well demarcated lesions are apt to be benign. Large tumors with poorly defined borders, cortical destruction, and/or periosteal reaction suggest malignancy.

Potentially helpful laboratory studies include a complete blood cell count, sedimentation rate, alkaline and acid phosphatases, and serum electrophoresis; however, no diagnosis is possible without tissue confirmation.

Before the biopsy, tumor localization is helpful. Tomograms may help define the extent of a tumor. A bone scan gives information about (1) biologic activity, and (2) location of other significant skeletal lesions which can then be selectively x-rayed. In extremity tumors when *resection* is planned, a biplane arteriogram gives important information, such as the soft tissue extent, vessel and nerve displacement, and vascular supply of the tumor.

In pelvic and shoulder girdle tumors, computed axial tomography provides orientation of tumor to normal bony and soft tissue structures.

Bone sarcomas metastasize most predictably to the lung; therefore, either whole lung tomograms or whole lung computerized tomographic (CT) scans are necessary for proper staging before definitive surgery.

The biopsy is done when biologic activity and localization studies are complete. This allows appropriate selection of site and correlation of the tissue with clinical studies. An open biopsy is used in virtually all primary bone malignancies. The incision is planned to allow its inclusion with resection or amputation. We feel it is important to do frozen sections on all tumors, even if the definitive procedure will be done at a later time. Frozen sections tell whether the pathologist has adequate tissue for diagnosis and suggest special stains, electron microscopy, or even bacterial cultures when appropriate.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

Management of bone sarcomas depends somewhat upon histologic characteristics. Primary malignancies of bone can be divided into two major groupings: (1) matrix-producing or mesenchymal cell-type tumors and (2) round-cell or marrow-origin tumors.

Mesenchymal-type tumors (osteosarcoma, chondrosarcoma, and fibrosarcoma) are treated surgically, since they are relatively radioresistant. Osteosarcoma is best treated by amputation except in rare instances. Chondrosarcoma lends itself to radical resection, because its microscopic projections remain close to the bulk of tumor.

Round-cell tumors (Ewing's sarcoma, histiocytic lymphoma of bone, and multiple myeloma) are relatively radiosensitive and may not require surgery other than biopsy. The involved bone may be irradiated with 5500-6000 rads.

The greatest contribution to the management of primary bone malignancies, especially osteosarcoma and Ewing's sarcoma, has been the development of adjuvant chemotherapy. Appropriate chemotherapy is started either at the time of surgery or concomitantly with radiotherapy. Methotrexate and doxorubicin hydrochloride (Adriamycin™) are the major drugs used. Various combinations have been used for 12-18 months following diagnosis and treatment of the primary tumor, increasing survival to 50%-60% at two years.

Management of primary bone malignancies is a complex multispecialty effort. Communication between the surgeon, pathologist, oncologist, and radiotherapist is vital for maximal care. Early diagnosis, decisive treatment of the primary, and the use of adjuvant chemotherapy have improved survival in this group of patients. Eventually limb preservation surgery may replace amputation as chemotherapy protocols become more effective in controlling microscopic disease.—THOMAS A LANGE, MD, Department of Orthopedic Surgery and Wisconsin Clinical Cancer Center, Clinical Science Center, Madison, Wisconsin 53792

Nutrition in Cancer as a Team Effort in the Community Hospital

The Wisconsin Clinical Cancer Center is planning a one-day conference for Friday, Dec 7, 1979, at the Clinical Science Center in Madison. It has been developed to expand the understanding and appreciation of nutritional support of the cancer patient as a team activity. It has been planned for medical oncologists, surgical oncologists, other interested physicians, nurse clinicians, and dietitians.

Human Oncology Grand Rounds

Human Oncology Grand Rounds are held each Wednesday morning from 8 to 9 AM in Madison at the UW Center for Health Sciences, Room G5/113.

Karl Beyer Lecture set

Jimmie Holland, Chief of the Psychiatry Service of the Memorial Sloan-Kettering Center, New York, has been selected to present the Karl Beyer Lecture at the Wisconsin Clinical Cancer Center, G5/119, in Madison on Thursday, October 11, at 5 PM. The title of her lecture will be "The Human Side of Cancer: A Psychiatric View of Oncology." ■

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Organizational SMS

Council endorses emergency immunization rule

In response to growing evidence that many Wisconsin children are not being immunized against the vaccine-preventable diseases, the SMS Council at its July 14 meeting voted to support a State Department of Health and Social Services emergency rule imposing minimum immunization requirements for the admission of all school children in grades K-12 in the 1979-80 school term. (See editorial in July issue of *WMJ*, page 9)

In other action July 14 the Council:

• Received a leadership update, including a review of the roles and responsibilities of councilors and officers, goals and objectives, committee and staff structure, finances, and duties and legal responsibilities of councilors and officers.

• Elected Antoine Barrette, MD, Peshtigo; Joseph M Jauquet, MD, Ashland; Richard W Edwards, MD, Richland Center; and reelected Timothy T Flaherty, MD, Neenah, to the SMS Services, Inc Board of Directors.

• Received a report that Wisconsin Review Foundation (WRF) Board of Directors July 11 voted to allow WisPRO to incorporate as a separate entity and that WRF will continue to exist with a purpose of encouraging, advising, and expediting private patient peer review in Wisconsin.

• Created a "cost containment committee" under the Physicians Alliance Commission with its major objectives to encourage establishment of similar cost containment committees by medical staffs of hospitals and county medical societies, support the Voluntary Effort, and launch an 18-point program of cost containment.

• Approved an SMS membership recruitment campaign for 1979-80 to be launched by the Physicians Alliance Commission with assistance from councilors and officers, and other SMS commissions.

• Approved plans for the 1979 Work Week of Health dealing with prospective medicine consisting of: (1) a conference for health educators in September, and (2) a television series aimed at students in October.

• Reelected the following nonmedical trustees to the CES Foundation: Mrs Audrey Baird, Wauwatosa; Mrs Nancy McDowell, Milwaukee; and Mrs Catherine McCormick, Shawano.

• Approved the following statement on continuing medical education credits: "The State Medical Society's Commission on Continuing Medical Education, in order to eliminate any potential confusion, firmly believes that only scientific and medical topics relating to the delivery of medical care should be eligible for Category I credit under the Physician's Recognition Award of the AMA."

• Formally opposed the "guilt by association" provision currently contained in the Medical Assistance SuperRule. The provision says that when a person who has five percent or more controlling interest in a corporation or serves as business manager for that corporation is "involuntarily terminated" for a five-year period from the Medical Assistance Program, all other members of that corporation can likewise be terminated from participating in the program.

• Took steps to develop in-house computer capability for the State Medical Society.

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

Health Care in the 80s to be explored at October 12 conference in Delavan

The State Medical Society of Wisconsin and the Wisconsin Hospital Association are cohosting a symposium on the future directions of the health-care system, Friday, October 12, at the Lake Lawn Lodge in Delavan.

"Health Care in the 80s: Options for Survival" will highlight for physicians, hospital administrators and board members contemporary health issues such as cost containment, alternative delivery systems, distribution of health resources, and effects of government regulation on the health system.

Congressman John Anderson (R-Illinois), a candidate for the Republican presidential nomination and ranking Republican on the House Rules Committee, will deliver a special luncheon address on health care in America.

Addresses by Walter McClure, PhD, vice-president of InterStudy in Minneapolis, and Ralph Andreano, PhD, professor of economics at the University of Wisconsin-Madison, will provide the

basis for discussion groups throughout the day. Doctor McClure will reexamine the incentives of the healthcare system today and the prospects for change in that system through marketplace incentives. The Wisconsin experience in healthcare delivery will be highlighted by Doctor Andreano.

Physicians are encouraged to attend this important conference. Brochures offering details of the program have been mailed to all SMS physicians. Further information may be obtained from Neal Neuberger of the SMS Health Services Division.

President Treffert sets record straight on "marijuana medicine"

The *Wisconsin State Journal* editorial entitled "Marijuana Medicine" (Aug 7, 1979) is in error and requires clarification, SMS President Darold A Treffert, MD, Fond du Lac, told SMS members in a special note accompanying the August 10 issue of MEDIGRAM.

Contrary to the editorial, SMS did not "endorse a bill similar to Clarenbach's." In fact, both the Committee on Alcohol and Drug Abuse and the Governmental Affairs Commission took a position in opposition to AB 107 (Rep Lingren's bill). On Mar 14, 1979, GAC concluded "that it does not oppose the concept of therapeutic use of marijuana but feels that the data and information obtained by research being conducted by other states and agencies is transferrable. The Commission felt that Wisconsin could obtain this data from other sources, therefore making this particular piece of legislation inessential. Likewise, the creation of another policy-making board could be avoided and no duplicative cost could be incurred by the state."

In Wisconsin there already is a mechanism through the research permit procedure of the Controlled Substances Board for persons to carry out valid research with marijuana and THC and a whole new panel and bureaucracy which would be part of AB 107 is unnecessary, Doctor Treffert stated. There is, in fact, research already being conducted under permit from the CSB by oncologists in Wisconsin relative to the question of the usefulness of THC in counteracting the nausea and vomiting in patients undergoing chemotherapy for cancer. Further, by using the procedure already in place in Wisconsin there is no necessity to reschedule marijuana from Schedule I to Schedule II, even in part, as AB 107 and AB 279 (Rep Clarenbach's bill) would require, Doctor Treffert concluded.

President Treffert writes Governor

"Wisconsin's present immunization 'crisis' would very likely never have occurred had the State Department of Health and Social Services maintained adequate physician input and leadership in matters of health," SMS President Darold A Treffert, MD, Fond du Lac, wrote in a letter to Governor Lee Dreyfus July 30 supporting promulgation of an emergency immunization rule by DHSS.

Referring to the DHSS's increasing emphasis on the financial and regulatory aspects of healthcare at the expense of public health programs, Doctor Treffert stated that "it is time to get back to certain medical basics if there is to be adequate public health protection for Wisconsin citizens in the future."

As reported in the July issue of *WMJ*, legal problems appear to be frustrating a department rule mandating the immunizations; and even a successful legislative process will delay implementation until next year.

Meanwhile the State Medical Society is urging all members to voluntarily seek to get all students in all schools immunized to the proper levels this fall. SMS urges local doctors to seek the assistance of local school officials to get the job done.

How to fight negative news coverage

What should physicians do when they hear or see their profession being attacked on radio, television, or in newspaper stories?

SMS Public Information Commission Chairman Herbert Sandmire, MD, Green Bay, offers some suggestions on what individual physicians can do in combating negative news coverage in the August 20 issue of *Medical Economics*.

In the article Doctor Sandmire urges physicians to stop turning the other cheek to negative publicity and to respond to negative stories. Perhaps the easiest method to do this is a letter to the editor. If time doesn't permit this, simply use the telephone to convey your comments on the story.

"In responding to news stories detrimental to medicine try to enhance your credibility by searching for some statement in the offending material with which you can agree," states Doctor Sandmire. "Then, in a clear and easily understood manner, describe the shortcomings of the article. Finally, try to theorize about reasons for the disputed statements, thus allowing the errant writer to escape with honor, and further increasing your own credibility."

Included in the *Medical Economics* article are reprints of portions of the State Medical Society of Wisconsin and Wisconsin Hospital Association's *Communications Guide for Wisconsin Hospitals and Physicians*, as well as innovative ideas and programs used by other state medical societies in working with the news media.

Annual Meeting scientific programs shaping up

Several high-quality scientific programs already have been lined up for the 1980 Annual Meeting in Milwaukee, March 28-29.

Edward P Horvath, MD, Marshfield, will present "Industrial Lung Disease" at the Emergency Medicine Section meeting.

Brian H Hoff, MD, San Antonio, Texas, is slated to speak on "Myocardial Oxygen Consumption and Coronary Blood Flow" at the Anesthesiology Section program.

Special guest speaker at the Pathology Section program will be F K Mostofi, MD, Washington, DC, talking on "New Developments in Genitourinary Pathology."

Lawrence Solomon, MD, Chicago, will present "Clinical Presentations in Melanoma" and "Immunology of Melanoma" at the Dermatology Section program.

Maurice Victor, MD, Cleveland, will give the luncheon address, "Effects of Alcohol on the Nervous System," at the Neurology Section program.

John R Amberg, MD, San Diego, Calif, will be the guest speaker at the Radiology Section program.

SMS annuity unit value: $2.69

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.69 as of July 31, 1979. At June 29, 1979 it was $2.68.

Annual Meeting program on JCAH standards for physicians slated

Physicians will have a chance to find out more about the JCAH (Joint Commission for Accreditation of Hospitals) standards that affect them at a special program the State Medical Society is cosponsoring with JCAH during the 1980 Annual Meeting in Milwaukee. The four-hour program, scheduled for Thursday, March 27, at 12 noon, will include presentations on: Medical Staff Privilege, Delineation and Reappraisal; Medical Staff Monitoring Functions; Quality Assurance Standard; and Medical Staff Organization, Staff Bylaws, Rules and Regulations.

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Physicians urged to help fight immunization problem

The Society's Commission on Public Information is spearheading a public awareness campaign aimed at reminding parents of the need for having their children immunized against the vaccine preventable diseases.

At its meeting August 15, the Commission voted to work with media outlets in the state in publicizing the present problem that many of the state's school-aged children are inadequately immunized.

The Commission also voted to send a letter to county medical society officers asking them to work with local school district officials in correcting immunization deficiencies in their communities.

In other action, the Commission:

• Lent its support to a membership recruitment drive being initiated by the Physicians Alliance Commission this fall. Commission members will suggest to the Council that it consider a special membership category for medical students to aid in future membership strategies.

• Endorsed development of a mini-brochure on the topics of pregnancy and smoking and pregnancy and drugs with the SMS Committee on Maternal and Child Health.

• Voted to send *Medigram* to chiets of medical staffs of all Wisconsin hospitals in an effort to communicate the activities of SMS with Wisconsin hospital medical staffs.

• Complimented the Commission on Mediation and Peer Review for its new brochure, "If You Have A Complaint About Medical Care." The Commission will be publicizing the availability of the brochure to physicians in the coming weeks.

• Reviewed a recent readership survey of *Medigram*. Since the majority of physicians responding indicated satisfaction with the present format and content of the newsletter, no revisions were recommended.

• Directed staff to prepare speech material for physicians who are asked to appear before local community service groups to explain what SMS is doing for patients.

• Reelected Herbert Sandmire, MD, Green Bay, chairman, and Mark Popp, MD, Brookfield, vice-chairman of the Commission.

Safe, inexpensive collection service available through SMS

Among the services available to SMS members is a safe, inexpensive debt collection program—one that has resulted in collections of more than $345 thousand for participating members.

The program, offered by IC System, Inc, provides reputable collection assistance to physicians throughout Wisconsin. IC complies with all provisions of both state and federal collection laws, operating within increasingly complex legal guidelines. Those who use its service are further protected by a Hold Harmless agreement which indemnifies them against the possibility of any claims resulting from the company's efforts to collect.

IC offers this service at a comparatively low rate. The cost to submit an account is usually less than $1.00. Thereafter, the only other cost is a 28% charge on money actually collected—a rate that drops to 10% on the amount over $500.

Members interested in learning more about IC can arrange to see a company representative by contacting the Society office or by calling IC's regional office, collect, at 312/381-5881.

SMS now CME accrediting body in state

Citing monumental problems with the Liaison Committee on Continuing Medical Education (LCCME), the AMA House of Delegates in June voted to withdraw from the LCCME and resume its role as the primary accreditor of CME-sponsoring organizations through the AMA Council on Medical Education. Effective July 25, the AMA recognized the State Medical Society of Wisconsin as the accrediting body for continuing medical education in Wisconsin. According to Bill Wendle, SMS Scientific Affairs Coordinator, some state associations had experienced administrative problems with the LCCME and were concerned over recent efforts by the accreditor to diminish the role of state associations through its proposed restructuring of the accreditation process.

SMS accredits 72 Wisconsin institutions, organizations

The SMS Commission on Continuing Medical Education and its Subcommittee on Accreditation have announced that 45 hospitals, 26 specialty groups and related health organizations, and one county medical society have been accredited so far this year. The accreditation by SMS means that these groups can offer Category I type programs accceptable to meet Wisconsin's 30-hour CME requirements.

SMS testifies on records access, x-ray certification

Representatives of the State Medical Society have been busy offering testimony before state Senate and Assembly committees in recent weeks on several pieces of proposed health-related legislation. Here is a summary of that testimony:

• **Access to patient records**—A Society legislative representative expressed concern to members of a Senate committee August 8 over SB 112 which proposes to allow various governmental and medical review agencies responsible for patient care review, facility licensure/approval and cost containment to have access to patient medical records without prior written consent from patients. The Society said the legislation was not specific enough as to what types of agencies and organizations would have access to medical records.

SMS suggested alternative language for the bill which would continue to enforce the concept that communications between physicians and patients are privileged information. However, the alternative bill language would allow for a patient's medical record to be released without written consent for purposes of consultation, or pursuant to a court order, and would allow the information to be released without the disclosure of the patient's name for purposes of peer review; accreditation, and for government inspection by duly authorized agents.

• **Patient access to medical records**—The Senate Human Services Committee also heard testimony from Society representatives August 22 in regard to SB 260 on patient access to medical records. The Society said that the bill's provision allowing patient access to medical records already existed in Chapter 804.10 of the Statutes. The Society urged as an alternative to SB 260 that this section be amended to include records held by other health providers in addition to physicians. Objections were also raised to a provision in the bill requiring that the independent judgment of a psychiatrist be used before releasing records of a patient in treatment to whom such information could be medically damaging. SMS believes that the attending physician for the patient should be allowed to make this judgment.

• **Certification of x-ray operators**—Whether the State should certify x-ray machine operators was the issue discussed at a public hearing held August 21 in Madison. A spokesperson for the Society urged the Assembly Committee on Health and Social Services to postpone action on AB 824 until results of efforts already underway in this area can be evaluated. These include: establishing an ad hoc committee, as mandated in the State Health Plan, to study the safety, exposure and competency of x-ray providers; evaluating of the NEXT (National Evaluation of X-ray Trends) resurvey of state x-ray facilities which will be completed within the year; and examining the effectiveness of Radiation Protection Code (H-57) currently being recodified.

WISPAC given Leadership Award

The Wisconsin Political Action Committee (WISPAC) has received a Leadership Award from the American Political Action Committee (AMPAC) for its achievements in WISPAC and AMPAC membership in 1979. To qualify for the award, a political action committee must have all State Medical Society officers as sustaining members of the state and national political action committees.

SMS tapping into ETN

The SMS Health Services Division, in cooperation with the University of Wisconsin Department of Continuing Medical Education, is planning a series of programs on selected socioeconomic topics over the state Educational Telephone Network (ETN) for later this fall. Watch future issues of MEDIGRAM for details.

CONTRIBUTIONS CES FOUNDATION JULY 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1979.

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Wisconsin Rural Rehabilitation Corp; Sauk Prairie Memorial Hospital—*Medical Student Summer Externship Program*

Memorials

Dane County Medical Society—*William L Caldwell, MD; AR Curreri, MD; John B Wear Jr, MD*
State Medical Society—*William J Tucker, MD;* Rhoda E Lorton, MD; *Sylvester E Coffey, MD*
The Donald M Rowe Family—*Irene Erickson (Medical Careers Loan Fund of Sheboygan County)*
Michael R McCormick, MD—*John B Wear Jr, MD*
Margaret A McCormick—*Mrs Peter D Humleker Sr*
Dr Richard Edwards Family & Edith Tuxford—*Carl Meadows*

Medical leaders return from goodwill tour

A 32-member delegation of Wisconsin physicians and spouses recently returned from a two-week People-to-People goodwill tour to Sweden, the Soviet Union, and Switzerland.

The Goodwill People-to-People Program was established by President Eisenhower to foster better understanding between the peoples of the world, and more specifically, those belonging to the same professions in different countries whether it be medical, legal, financial, agricultural, educational, etc.

While on the tour, physicians had the opportunity to visit medical facilities in Stockholm, Moscow and Zurich, and to compare methods and procedures with physicians in the same specialties as themselves.

According to Roy B Larsen, MD, Wausau, coordinator of the event, the physicians found the experience to be most worthwhile both "educationally and culturally."

Doctor Larsen said the group is planning a "reunion" in October to "review experiences, pictures, and our written experiences."

Physicians taking part in the People-to-People tour were: Roy B Larsen, Wausau; Vernon M Griffin, Mauston; Francis C Johnson, Wausau; Dale V Moen, Shell Lake; David E Papendick, Algoma; J Garry Sack, Wausau; Jack K Burr, Appleton; Roy Hong, Wild Rose; Sandra L Osborn, Madison; Audrey S Huckaby, Cedarburg; P Richard Sholl, Janesville; Herbert F Sandmire, Green Bay; John O Simenstad, Osceola; Kenneth M Viste Jr, Oshkosh; Richard Biek, Waupaca; William P Young, Madison; James F Zimmer, Hales Corners; and Menandro V Tavera Jr, Lake Geneva.

Accreditation Manual for Hospitals—1980 edition

THE 1980 EDITION OF THE *Accreditation Manual for Hospitals (AMH)*, which represents the first complete revision of the manual since 1970, is now available from the Joint Commission on Accreditation of Hospitals. In addition to an important new quality assurance standard, the 1980 edition contains revised governing body, hospital-sponsored ambulatory care services, management and administrative services, nursing services, and utilization review standards. Other highlights of the 1980 edition include a new preface to the standards, revised survey eligibility criteria, revised glossary definitions, an appendix that delineates all changes made by the Board of Commissioners since publication of the 1979 edition, and an updated index. Revised standards, with the exception of the quality assurance standard, become effective for accreditation purposes on January 1, 1980. The Board of Commissioners will determine the effective date for the quality assurance standard at a future date, the JCAH announced.

Hospital Survey Profile—1979 edition

THE MOST IMPORTANT publication for an accredited hospital next to the *Accreditation Manual for Hospitals*, the *Hospital Survey Profile* provides hospitals with an easy method of obtaining an overview of hospital operations, evaluating hospital practices, and preparing for an accreditation survey. The 1979 edition of the *HSP* reflects the late revisions in the *AMH* and incorporates valuable suggestions from the field. Over 2,500 completed *Profiles* were reviewed and almost 2,000 suggestions from individuals and organizations were considered in preparing this edition. Many items have been added, reworded, or reordered to facilitate precise assesment of hospital services. Because of this *HSP* is consistent with the 1980 edition of the *AMH*, it will also provide hospital staff with a preview of what JCAH surveyors will look for after January 1, 1980, when the revised standards (except for quality assurance) become effective for accreditation purposes.

Copies available

EACH ACCREDITED HOSPITAL receives a complimentary copy of the 1980 *AMH* upon publication. Copies of the *HSP* are sent to a hospital before its accreditation survey to complete and return to JCAH. Additional copies of each publication may be purchased from JCAH at the following rates: *AMH*—$20/copy; *HSP*—$12.50/copy; quantity discounts available. Send order with payment to: Publications Sales Department, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave, Chicago, Ill 60611.

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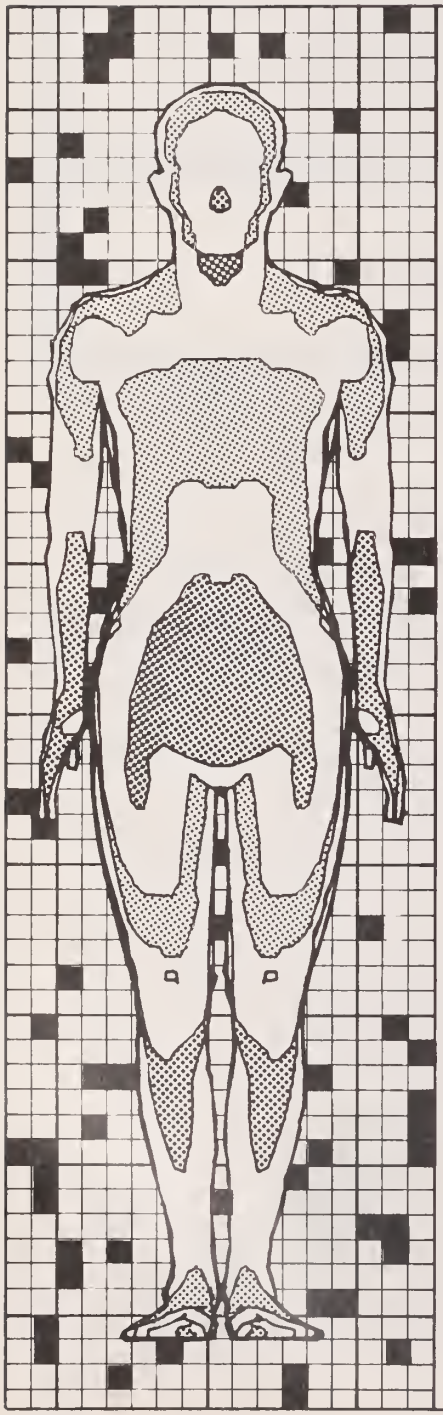
HEALTH CARE IN THE '80s:

OPTIONS FOR SURVIVAL

Presented by
The State Medical Society of Wisconsin
Health Planning Commission
and
The Wisconsin Hospital Association
October 12, 1979
Lake Lawn Lodge
Delavan, Wisconsin

A symposium for physicians, hospital chief executive officers, and board members focusing on future directions in the health care system. Health planning mandates, government regulation and marketplace incentives will be examined to determine their impact on health care delivery now and in the future.



PROGRAM

Thursday, October 11

5:30-7:00 p.m. Registration and Informal Social Hour

Friday, October 12

8:00 a.m. REGISTRATION. Coffee and rolls will be served.

8:45 a.m. WELCOME—Leo Bargielski, Chairman, Wisconsin Hospital Association Executive Director, Watertown Memorial Hospital; Darold Treffert, M.D., President, State Medical Society of Wisconsin, Clinical Director, Fond du Lac Mental Health Center

9:00 a.m. ADDRESS by Walter McClure, Ph.D., Vice President of InterStudy, Minneapolis, Minnesota

A re-examination of the incentives in the health care delivery system. Included will be an in-depth look at linkages between patient, provider, and the health care insurer. An explanation of system breakdown with regard to cost containment, distribution of health resources, and how government regulation has affected these problems. Consideration of the prospects for change in health care delivery through marketplace incentives.

Questions and Answers

10:00 a.m. Coffee Break

10:15 a.m. DISCUSSION GROUPS — an opportunity to examine Dr. McClure's remarks, to discuss their application in Wisconsin and to explore options for cooperative efforts between physicians and hospitals in the areas of cost containment, government regulation, physician distribution, and alternative delivery systems.

1. **Cost Containment**
   Discussion led by:
   Blake Waterhouse, M.D., Madison
   Paul Kempe, Administrator, Columbia Hospital, Milwaukee
2. **Government Regulation**
   Discussion led by:
   Marcia Richards, M.D., Milwaukee
   George Seidenstricker, Administrator, St. Alphonsus Hospital, Port Washington
3. **Physician Distribution**
   Discussion led by:
   James Moore, M.D., Madison
   Paul Markgren, Administrator Lakeside Hospital, Rice Lake
4. **Alternative Delivery Systems**
   Discussion led by:
   Cyril Hetsko, M.D., Madison
   David Jaye, Jr., President, St. Joseph's Hospital, Marshfield

11:30 a.m. REPORTS FROM DISCUSSION GROUPS

12:15 p.m. Luncheon, Special Address: **The Future of Health Care in America**—The Honorable John Anderson of Illinois, Member, U.S. House of Representatives

1:30 p.m. ADDRESS by Ralph Andreano, Ph.D., Professor of Economics, University of Wisconsin-Madison, Former Administrator, State Division of Health

An overview of health care delivery in Wisconsin with particular attention focused on the effectiveness of state cost containment mechanisms including hospital rate review, certificate of need, and decertification. An assessment of regulatory, legislative, and planning initiatives in Wisconsin as they relate to the health care system. Consideration of expected changes in health care delivery in Wisconsin.

Questions and Answers

2:30 p.m. Coffee Break

2:45 p.m. REACTOR PANEL—A Critique of Dr. Andreano's Remarks.
Walter Harden, Executive Director, Family Hospital, Milwaukee; Guenther Pohlmann, M.D., Milwaukee; Roger Rheeling, Assistant Vice President, Operations, Rural Security Insurance; State Senator Paul Offner, La Crosse

Questions and Answers

3:45 p.m. PERSPECTIVES ON THE FUTURE, Warren Von Ehren, President, Wisconsin Hospital Association; Earl Thayer, Secretary and General Manager, State Medical Society of Wisconsin

4:15 p.m. ADJOURNMENT AND RECEPTION

HEALTH CARE IN THE '80s: OPTIONS FOR SURVIVAL
FRIDAY, OCTOBER 12—LAKE LAWN LODGE—DELAVAN

Featured Speakers

Walter McClure, Ph.D.

Dr. McClure is vice-president and director of health policy and planning for Inter-Study, an independent policy research organization located in Minneapolis, Minnesota. His interests are the improved delivery and financing of medical care and his special concern is in developing strategies to introduce effective private competitive forces in the medical care system. He has authored numerous papers on issues, including private and public approaches to national health insurance. He has been a consultant to HEW, various Congressional committees and several states as well as to medical, hospital, business and labor organizations. Dr. McClure's formal training is in theoretical nuclear physics. He received his Ph.D. from Florida State University.

U.S. Rep. John Anderson

John Anderson, U.S. Congressman from Illinois, is the third ranking Republican in the House of Representatives. He is chairman of the House Republican Conference and a senior member of the Rules Committee. Regarded as one of the House's leading orators, he has been a major Congressional spokesman on issues ranging from election reform and health policy to energy. Congressman Anderson attended the University of Illinois where he was Phi Beta Kappa and graduated from its law school. Later, he was awarded a fellowship to Harvard Law School, where he received a Master of Law degree. He has authored and contributed to many books and publications on American politics including "The Future of the American Presidency." He is a candidate for the 1980 Republican presidential nomination.

Ralph Andreano, Ph.D.

Dr. Andreano is a professor of economics at the University of Wisconsin - Madison and serves as director of the University's Health Economics Research Center. In 1977, he left the academic community to become administrator of the State Division of Health. A leading authority on the economics of health, Dr. Andreano served as a chief economist at the World Health Organization (WHO) in Geneva, Switzerland from 1973-74. While at the WHO he was one of the authors of the WHO policy on Primary Health Care and Rural Development. A Fulbright Scholar, Dr. Andreano received his Ph.D. from Northwestern University and is the author of several articles and books on the economics of health care.

REGISTRATION FORM

Name _____

Street _____

City _____

State _____ Zip _____ Phone _____

Registration Fee: $20.00 includes coffee and lunch.
Make checks payable to: State Medical Society of Wisconsin

Morning Discussion Group Preference:
(Choose one)

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- Government Regulation
- Physician Distribution
- Alternative Delivery Systems

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Health Services Division
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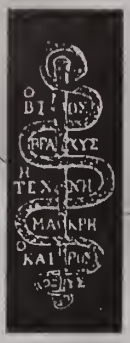

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1979 WISCONSIN RAPIDS SEMINAR FOR PHYSICIANS

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WEDNESDAY, OCTOBER 31, 1979

in cooperation with

Wisconsin Valley Chapter—Wisconsin Academy of Family Physicians

LOCAL COORDINATORS: **Jung K Park, MD,** Wisconsin Rapids; and **John E Thompson, MD,** Nekoosa

REGISTRATION FEE: (Including lunch) $25 for SMS, WAFP, and WAOP&S members. Non-members SMS, WAFP, WAPO&S: $50. Make check payable to: CES Foundation, and mail to CES Foundation, PO Box 1109, Madison, Wis 53701

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This program is a membership service of the State Medical Society of Wisconsin

9:00 am—**Registration** (coffee and rolls)

9:30 am—**Common ENT Problems in Family Practice: How to Treat and When to Refer**
James K Jones, MD, Wisconsin Rapids

10:30 am—Break

10:45 am—**Recent Advances in Antibiotic Therapy**
Dennis G Maki, MD, Madison, Head, Infectious Disease Section, UW Medical School

12:00 N—Luncheon

12:45 pm—**Prophylactic Use of Antibiotics in Surgical Cases**
Dennis G Maki, MD, Wisconsin Rapids

1:45 pm—Break

2:00 pm—**The Indications and Usefulness of Echo Cardiography**
W Bruce Fye, MD, Marshfield Clinic, Marshfield

3:00 pm—Adjournment

Pre-registration recommended

For information contact:

Bill Wendle

Scientific Affairs Coordinator

or

Arlene Meyer

Administrative Assistant for Continuing Medical Education

608/257-6781
or
1-800/362-9080
(toll-free)

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of August 8, 1979

NEW MEMBERS

County Medical Society

BROWN

Hathway, Stephen D, 744 S Webster Ave, Green Bay 54305 (1941, Regular, Clinical Pathology, Certified)
Swelstad, Jack A, 845 S Webster Ave, Green Bay 54301 (1945, Regular, General Surgery/Cardiovascular Surgery, Certified-GS)

DANE

Choate, Jennifer J, H4/544 Cl Science Ctr, 600 Highland Ave, Madison 53792 (1949, Resident, Internal Medicine/Hematology, Certified-IM)
Diggs, Charles H, 1313 Fish Hatchery Rd, Madison 53715 (1946, Regular, Internal Medicine, Certified)
Harrison, James E, 7023 Parkshore Ct, Middleton 53562 (1950, Resident, Otorhinolaryngology)
Kurtz, Jeffrey A, 6723 Spring Grove Ct, Middleton 53562 (1947, Resident, Plastic Surgery, Certified-GS)
Mantovani, John F, 1313 Fish Hatchery Rd, Madison 53715 (1949, Resident, Internal Medicine)
Rowe, Lewis L, 2138 Allen Blvd, Middleton 53562 (1950, Resident, Pathology)
Zonnebelt, Steven M, 2618 McKenna Blvd, Madison 53711 (1951, Resident, General Surgery)

FOND DU LAC

Fownes, Douglas R, 505 E Division St, Fond du Lac 54935 (1945, Regular, Family Physician, Certified)

LINCOLN

Sanan, Omer K, 216 N 7th St, Tomahawk 54487 (1950, Regular, General Surgery/General Practice)

MILWAUKEE

Beroukhim, Feridoun, 2400 S 90th St, Milwaukee 53227 (1936, Regular, Neurology/Child Neurology, Certified-N)
Bliwas, Crain H, 2200 W Kilbourn Ave, Milwaukee 53233 (1947, Regular, Psychiatry, Certified)
Collis, Jane M, 1938 Ludington Ave, Wauwatosa 53226 (1949, Regular, Ophthalmology)
Klehm, David H, 610 N 19th St, Milwaukee 53233 (1949, Regular, Family Physician, Certified)
McManus, Douglas B, 950 N 12th St, Milwaukee 53233 (1950, Resident, Internal Medicine)
Quiroz, Francisco A, 8700 W Wisconsin Ave, Milwaukee 53226 (1947, Resident, Diagnostic Radiology, Certified-R)

RACINE

Newman, Julian J, 500 Walton Ave, Racine 53402 (1930, Regular, Psychiatry, Child Psychiatry, Certified-P)

WAUKESHA

Krieger, Robert W, 915 E Summit Ave, Oconomowoc 53066 (1949, Regular, Pediatrics)
Schamberg, Jay F, S47 W22060 Lawnsdale, Waukesha 53186 (1942, Regular, Pathology/ Clinical Pathology, Certified-PTH)

WOOD

Rechsteiner, Norman, 1000 N Oak Ave, Marshfield 54449 (1952, Resident, General Surgery)

CHANGE OF ADDRESS

(Does not include those within a city)

BROWN

Barta, Rudolph A Jr, Green Bay, to 10818 Caprock Circle, Dallas, TX 75218
Hein, William E, Green Bay, to Rte 2, Box 197, Monroe 53566

DANE

Adib, Khosro, Madison to 6123 Sun Valley Parkway, Oregon 53575
Calvert, James F Jr, Madison, to 172 Franklin Ave, Pocatello, ID 83201
Goodenough, David J, Middleton, to 135 Eastwood Ave, Utica, NY 13501
Hipshman, Laurence, Middleton, to 425 Surf St, #803, Chicago, IL 60657
Holmes, Russell E, Madison, to 405 University Dr, East Lansing, MI 48823
Kalin, Ned H, Madison, to 6700 Glen Oak Court, Rockville, MD 20855
Marek, Robert W, Madison, to 929 N Astor St, #207, Milwaukee 53202
Narsete, Thomas A, Madison, to 8441 Yeager NE, Albuquerque, NM 87109
Nepple, Earl W, Madison, to 6471 Merry Meadow Dr, Dallas, TX 75231
Pitts, F R Jr, Madison, to Colonia Del Prado, Cuidad Colon De Mora, Costa Rica
Taylor, Donald J, Madison, to 1015 West Pleasant St, Portage 53901

GREEN

Chanbusarakum, P, Monroe, to 335 Island Dr, Madison 53705

JEFFERSON

Wilson, Douglas D, Watertown, to 2370 Southeast Blvd, Salem, OH 44460

KENOSHA

Valaske, Martin J, Great Lakes, IL, to 9910 Hillridge Dr, Kensington, MD 20795

MILWAUKEE

Ackerman, Eugene J, Hollandale, FL, to 4819 South Packard Ave, Cudahy 53110
Bergin, Steven C, Wauwatosa, to 2501 North Main St, Stevens Point 54481
Devan, Douglas G, Milwaukee, to 7700 Cooper Rd, Kenosha 53142
Kumar, P Pramod, Greendale, to 15275 Hidden Glen Ct, Elm Grove 53122
Mader, Michael H, Wauwatosa, to 1836 South Ave, LaCrosse 54601
Morgan, Sherburne F, Roswell, GA, to 156 St Clair Circle, Crowley, TX 76036
Nemeth, Charles, Marcy, NY, to Drawer A, Atascadero, CA 93422

ONEIDA-VILAS

Saunders, Reynolds J, Rhinelander, to 7932 East Presidio Rd, Tucson, AZ 85712

OUTAGAMIE

Sullivan, C J P, Appleton, to 15242 Chalet Dr, San Antonio, TX 78232

PIERCE-ST CROIX

Scheibel, William R, New Richmond, to 203 Melody Lane, Verona 53593

RACINE

Conley, Donal T, Waterford, to 20 Linda Mar, St Augustine Beach, FL 32084

ROCK

Meyer, Frederick N, Janesville, to 2300 South Hope St, Los Angeles, CA 90007

VERNON

Boehme, Larry R, Saginaw, MI, to PO Box 374, Hillsboro 54634

WINNEBAGO

Letellier, Marc A, Appleton, to 4085 Winnegammie Rd, Neenah 54956

Petersen, Gordon W, Appleton, to 7300 West Dean Rd, Milwaukee 53233

DEATHS

Levin, Abraham J, Milwaukee County, June 2, 1979
Regan, David M, Winnebago County, June 25, 1979
Morgan, James E, Milwaukee County, June 28, 1979
MacLean, Cyril R, Manitowoc County, June 30, 1979
Zautcke, Alvin B, Milwaukee County, July 5, 1979
Jeffers, Dean H, Walworth County, July 26, 1979
Leiby, Rowland W Jr, LaCrosse County, July 28, 1979 ■

Obituaries

◈County, State, AMA Members

◈ **John Brewster Wear Jr, MD,** 49, Madison, chairman of the University of Wisconsin Medical School's Department of Urology, died May 25, 1979 in a tragic airplane crash in Chicago. Born Oct 27, 1929, in Madison, Doctor Wear graduated from the University of Wisconsin Medical School, Madison, in 1954, and had been on the Medical School faculty since 1961. His faculty appointments started as an instructor in the Section of Urology, Department of Surgery; he became a full professor in the Section in 1971. He also was a senior consultant to the Veterans Administration Hospital in Madison. He was a member of many specialty societies and held office in most of them, including president of the Wisconsin Urological Society. At the UW-Madison he served on many committees including medical records, tissue, admissions, renal transplantation, hospital board, search, curriculum, faculty advisory, and the Task Force for the new Center for Health Sciences. A highlight of his career was a tour of duty on the SS HOPE, the hospital ship serving underdeveloped countries, April 13 to June 15, 1972. He was a staunch supporter of organized medicine and served on the State Medical Society's Commission on Mediation and Professional Ethics. In a letter to Doctor Wear's widow, SMS Secretary Earl Thayer expressed the Society's sorrow: "He was a tower of strength as a member of our Mediation and Ethics Commission which dealt with complaints of patients about physicians. He was part of the conscience of medicine; warm and compassionate, yet properly demanding of perfection in the art and science of medical care." Surviving are his widow, Elise, and four sons, Randy, Bruce, Scott, and Bart.

Doctor Wear

◈**Abraham J Levin, MD,** 70, Milwaukee, died June 2, 1979 in Rochester, Minn. Born May 1, 1909 in Liverpool, England, Doctor Levin graduated from Marquette University School of Medicine in 1933. Doctor Levin served in the United States Army from 1944-1946. He was a fellow in the American College of Surgeons. A general surgeon, Doctor Levin was active in his medical practice until May 15, 1979. Surviving is his widow, Lucille.

◈ **Rhoda Johnson Lorton, MD,** 55, Shorewood, died June 21, 1979 in Milwaukee. Born June 9, 1924 in Rio, Doctor Lorton graduated from the University of Wisconsin Medical School, Madison, in 1954. Her residency in obstetrics and gynecology was completed at Columbia Hospital, Milwaukee, and Evanston Hospital, Evanston, Ill. Her psychiatric residency was completed at the Milwaukee County Mental Health Center. Doctor Lorton was a staff psychiatrist at the Milwaukee County Mental Health Center and was on the medical staff of Milwaukee Psychiatric Hospital. She also was a clinical instructor at the Medical College of Wisconsin. Surviving are her husband, Dr William L Lorton, and a stepson, Todd D of Milwaukee.

◈ **David M Regan, MD,** 66, former Neenah physician, died June 25, 1979 in Sacramento, Calif. Born Dec 3, 1912 in Hartford, Doctor Regan graduated from Marquette University School of Medicine in 1937. He served in the United States Army during World War II from 1942-1945. Doctor Regan practiced medicine in Berlin prior to moving to Neenah in 1945. He had served as chief-of-staff of Theda Clark Memorial Hospital in 1966 and 1977. Surviving are four daughters, Mrs Samuel (Mary) Mirabito, Niantic, Conn; Mrs Michael (Virginia) Burgess, Sacramento, Calif; Mrs George (Marjorie) Wardingham, Milwaukee, and Miss Barbara Regan, Chico, Calif; two sons, Michael, Dubuque, Iowa, and John with the United States Air Force in Germany.

◈ **James E Morgan, MD,** 76, Milwaukee, died June 28, 1979 in Milwaukee. Born Dec 26, 1902 in Edgerton, Doctor Morgan graduated from Mar-

County Societies

WAUKESHA. Waukesha County Medical Society officers for the period June 1, 1979 to July 1, 1980 have been announced as follows:

President—Walter E Gager, MD, Waukesha

President-elect—Lee Tyne, MD, Brookfield

Secretary—Michael R McCormick, MD, Waukesha

Treasurer—Matthew Meyer, MD, Waukesha

Executive Secretary—Mr Robert H Herzog, Elm Grove

Board of Censors—Peter N Madden, MD, (chairman), Brookfield; Gary O Iverson, MD, Menomonee Falls; and Richard C Zimmerman, MD, Menomonee Falls

Grievance Committee—Charles A Desch, MD (chairman), Waukesha; Thomas Hofbauer, MD, Menomonee Falls; and La Vern Herman, MD, Waukesha

Delegates to State Medical Society—G Daniel Miller, MD (1980), Oconomowoc; John D Riesch, MD (1980), Menomonee Falls; Wayne Konetzki, MD (1981), Waukesha; Kenneth Dempsey, MD (1981), Menomonee Falls; and Thomas Hofbauer, MD (1981), Menomonee Falls

Alternate Delegates—William Davies, MD (1980), Waukesha; Mark Popp, MD (1980), Brookfield; Ronald Darling, MD (1981), Waukesha; Charles Holmberg, MD (1981), Hubertus; and Michael Janowak, MD (1981), Oconomowoc

Chairman, Physicians Alliance—Mark Popp, MD, Brookfield.

All of the above comprise the Executive Committee.

The Waukesha County Health Department has announced the opening of a Countty Venereal Disease Clinic in the Waukesha County Court House, 515 Moreland Blvd (Phone: 547-1200). It is open Thursday evening and Friday mornings. The medical director is Jay Schamberg, MD, Waukesha. ■

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quette University School of Medicine in 1933. He served in the United States Navy during World War I. A general surgeon, Doctor Morgan had practiced in the Milwaukee area until his retirement in 1973. Surviving are his widow and seven children.

◈ **Cyril Rankine MacLean, MD,** 74, Manitowoc, died June 30, 1979 in Rochester, Minn. Born June 23, 1905 in Nova Scotia, Canada, Doctor MacLean graduated from the University of Toronto in 1933. He practiced medicine in Timmins, Ontario, Canada, for 17 years and also served in the Royal Canadian Air Force for two years. He served a residency in anesthesiology at the Lahey Clinic, Boston, Mass, and came to Memorial Hospital in Manitowoc in 1953. Doctor MacLean had served as president of the medical staff at Memorial Hospital and retired in 1977. Surviving is his widow, Edna of Manitowoc.

◈ **Alvin B Zautcke, MD,** 52, Pewaukee, died July 5, 1979 in Milwaukee. Born Sept 16, 1926, Doctor Zautcke graduated from Marquette University School of Medicine in 1953. He served in the United States Navy from 1945-1946. A radiologist, Doctor Zautcke was on the medical staff of St Francis Hospital. Surviving are his widow, Ranae, and two daughters, Cindy and Kathy. ■

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1979

1 Health Care Coalition
2 EPSDT Technical Advisory Committee
8 WisPRO Advisory Group
9 WisPRO Management Committee
9 WisPRO Due Process Meeting
10 WisPRO Review and Evaluation Committee
13 Health Planning Council Physicians Task Force—Area I
15 SMS Committee on Alcoholism and Other Drug Abuse
15 SMS Commission on Public Information
17 SMS Committee on Mental Health
21 PSRO Reimbursement Workshop
21 Wisconsin Immunization Initiative Coordinating Committee
24 T-19 Oversight Committee
29 Constitution and Bylaws Committee
30 SMS Committee on School Health

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis. ■

Specialty Societies

WISCONSIN ACADEMY OF FAMILY PHYSICIANS. New officers of the WAFP are shown above (left to right): James N Moore, MD of Madison, immediate past president and now chairman of the Board of Directors; Robert F Purtell Jr, MD, Milwaukee, the new president; and John O Grade, MD, Elm Grove, president-elect. Charles L Steidinger, MD, Platteville, is the new secretary-treasurer.

A FAMILY AFFAIR. Robert F Purtell Sr, MD (above left) served as the ninth president of the Wisconsin Academy of Family Physicians in 1957. Robert F Purtell Jr, MD was installed as the 32nd president of the WAFP at its annual meeting earlier this year. They practice together in Milwaukee. Both also served as president of the Marquette-MCW Medical Alumni Association. Doctor Purtell Sr graduated from the Marquette School of Medicine in 1931, and Doctor Purtell Jr in 1961. ■

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AGS MEMBER AMERICAN GEM SOCIETY

WPS

report

for Wisconsin Physicians

Volume VIII, Number 5

September, 1979

WPS IS NAMED STATEWIDE PART B CARRIER

Since 1966, WPS has served as the Medicare, Part B (physicians services) carrier for all Wisconsin except the greater Milwaukee area. Because of WPS' proven record of cost effective claim processing and benefit administration, the Social Security Administration (SSA) recently made a summary award of the Part B Medicare service contract for the Milwaukee area to WPS. WPS will assume the Milwaukee area Part B service contract October 1.

Through this award, WPS-Medicare will provide service to over 575,000 Wisconsin beneficiaries and process almost three million claims during the 1980 Fiscal year. SSA is expected to save in excess of one million dollars in administrative processing cost per year by this action since WPS consistently has among the lowest administrative costs per claim of all Medicare processors in the nation.

The WPS-Medicare claim processing operations will remain located in the Madison headquarters. Physicians, suppliers, and beneficiaries in the Milwaukee area as well as the rest of the state will send their Medicare claims and correspondence to the same address:

Medicare
P.O. Box 1787
Madison, Wisconsin 53701

WPS offers an array of services to support its expanded Medicare operations. Professional Relations staff will conduct seminars in the Milwaukee area for medical assistants and interested physicians/suppliers on the WPS-Medicare claims processing system to assure that the carrier change is effectuated smoothly. The workshops are scheduled for the following dates, times, and locations:

DATE	TIME	LOCATION
Sept. 11	9:00 - 11:30 am	Holiday Inn -- West 201 North Mayfair Rd.
Sept. 12	9:00 - 11:30 am	Holiday Inn -- Central
Sept. 12	1:00 - 3:30 pm	1926 West Wisconsin Ave.
Sept. 13	9:00 - 11:30 am	Holiday Inn -- Central
Sept. 13	1:00 - 3:30 pm	1926 West Wisconsin Ave.

A workshop is scheduled for podiatrists and their office staffs:

DATE	TIME	LOCATION
Sept. 11	1:30 - 3:30 p.m.	Holiday Inn -- West 201 North Mayfair Rd.

The WPS-Medicare informational manuals have also been updated to reflect WPS' expanded operations and responsibilities. The manuals will be distributed at the workshops and are also available directly from WPS at the following address:

Wisconsin Physicians Service
P.O. Box 1787
Madison, Wisconsin 53701
Attention: Elnora Johnson, CPCU

WPS representatives are available to answer any questions relating to the changeover at the toll-free WPS telephone number, 1-800-362-7221. WPS looks forward to the increased challenges and responsibilities associated with the assumption of statewide Medicare Part B administration.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

11440-006-7908

CONTRACT EXCLUSIONS

Excessive paperwork harms the efficiency of both your office and WPS. It is expensive for your office to process claim forms for services that are not benefits of regular WPS policies. The following is a description of the most common exclusions found in WPS health insurance contracts. With it, you can advise your office's patients whether or not they may expect insurance coverage and perhaps discourage the filing of unnecessary claim forms.

Remember that the following list contains standard exclusions on **all** WPS policies. Certain WPS policies may contain **other** exclusions not discussed here. If you need to know if a service is covered under a patient's specific WPS policy, obtain the patient's seven-digit subscriber number and contact WPS Inquiry Services (608-221-4711).

No WPS policy provides benefits for:

- Anything covered by Workers' Compensation or the United States Veterans Administration.
- Anything covered by other federal, state, or local government agencies unless the patient must pay for all or a portion of those services.
- Any services, supplies, or equipment provided before the date that WPS coverage goes into effect or before the completion of any applicable waiting period.
- Care of any condition caused by any type of military action, atomic, or thermonuclear explosion or radiation.
- Physical examinations designed to provide health information for a third party, such as for schools, employers, insurance companies, sports, marriage, or summer camps.
- Laboratory and x-ray procedures associated with such physical examinations.
- Laboratory and x-ray procedures not related to the diagnosis.
- Anything for purely beautifying or cosmetic purposes unless (under some contracts) necessitated by accident.
- The examination, treatment, or removal of corns, callousities, and similar foot conditions including trimming or partial removal of toenails.

The preceding list is another feature of the WPS effort to make claims filing procedures as simple and efficient as possible.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 30¢ per word, with a minimum charge of $12.00 per ad. BOXED AD RATES: $15.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

Physicians Exchange

PHYSICIAN(S) INTERESTED IN family practice to locate in Baldwin, Wis. Excellent hospital facilities located adjacent to Clinic. Offers excellent family environment and a variety of recreational activities. 40 minutes east of St Paul, Minn. Contact Gordon Palmer. Admin, Baldwin Community Hospital, Baldwin, Wis 54002. Tel: collect 715/684-3311. 7-9/79

GONZALEZ MEDICAL CENTER is seeking a pediatrician who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, telephone 414/344-1120; 414/671-5410; 414/476-8624. 8-12/79, 1/80

THE WAUSAU MEDICAL CENTER, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Dermatology
- Neurology
- Orthopedics
- Otolaryngology (2)
- Radiology (2)

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, wirte John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 8tfn/79

WANTED: TWO FAMILY PHYsicians preferably ABFP for association with the Family Medical Center, Sheboygan, Wisconsin. Please call or write: Martin A Rammer, MD, 1930 N 8th St, Sheboygan, Wis 53081; phone 414-457-5016. 5tfn/78

OB-GYN: IMMEDIATE OPENing with 9-man, multispecialty group. To join present Ob-Gyn, four internists, two pediatricians, and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing—pension plan. Young group. Contact James L Algiers, MD or Clinic Manager, Parkview Medical Associates, Ltd, 1004 East Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/79

MULTISPECIALTY GROUP OF 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Dermatologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

MILWAUKEE HMO—2 FAMILY physicians needed for innovative group practice. New multi-million dollar facility with full support services located in the suburb of Greenfield. Present staff includes four family practitioners, a physician's assistant and a nurse practitioner. Congenial atmosphere, four day week, light call. Attractive salary and fringe benefits. Contact Philip Eckstrom, MD, Family Health Plan, 6901 W Edgerton Ave, Milwaukee, Wis 53220. Tel: 414/421-8400. 9-11/79

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

PHYSICIANS—WE SAVE YOU TIME AND KEEP YOUR SEARCH COMPLETELY CONFIDENTIAL

We're medical professionals ourselves so we recognize outstanding opportunities. Tell us your geographic and position choices and salary expectations. We'll match them with the career opportunities we have available in Wisconsin as well as nationwide. No charge to applicants.

Contact Adeline Horner, RN

HORNER MEDICAL PLACEMENTS
802 W Broadway, L-6M
Madison, WI 53713
Tel: 608/222-1616
Licensed Employment Agency

1tfn/79

Physicians Exchange

continued

WANTED: FAMILY PRACTICE physician to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

FAMILY OR GENERAL PRACtitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

GENERAL INTERNIST WITH GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info: J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

FAMILY PRACTITIONERS OR internist and pediatrician for satellite primary care office located in West Allis, Wis. Call shared by other members of 34-physician multispecialty group. For further information contact E Daun, Administrator, Northpoint Medical Group, 2388 N Lake Dr, Milwaukee, Wis 53211. Tel: 414/289-3918. 4tfn/79

WANTED: ORTHOPEDIC SURgeon to practice with one other orthopedic surgeon, multispecialty clinic, primary care oriented with 13 MDs. New hospital immediately adjacent to clinic. 65 miles from Minneapolis/St Paul on I-94. Ideal situation for family-oriented lifestyle. Recreation, time off, congenial group. Rapidly growing college community. No seniority and full status after one year. Competitive salary first year. Contact Rex Shaffer, Manager, or Dr James Haemmerle. Call collect 715/235-9671, or write Red Cedar Clinic, 2211 Stout Road, Menomonie, Wis 54751. 7-12/79

FAMILY PHYSICIAN: APPLEton, Wis, to join four certified ABFP physicians. City of 60,000—economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact: K E Buchanan, MD, 620 E Longview, Appleton, Wis 54911. Tel: 414/734-7144. 9-11/79

INTERNIST WANTED. POSItion immediately available in a multispecialty clinic in Madison, Wisconsin. Must be Board Eligible. Most specialties and subspecialties represented. Excellent clinical practice with teaching responsibilities available. Contact Dept 467 in care of the Journal. 7-9/79

FAMILY PRACTICE FACULTYMedical College of Wisconsin-Milwaukee. ABFP family physician to assume directorship of established Family Practice Residency at St Mary's Hospital, Milwaukee. New Family Practice Center embodying latest design for teaching and patient care, open June 1, 1979. Overlooks immediately adjacent Lake Michigan. Appointment would be as a full-time MCW faculty with highly competitive salary and fringes, and rank commensurate with experience. Duties would consist of teaching residents and medical students, patient care, administration and research opportunities. Present faculty skilled, experienced and cooperative. Milwaukee enjoys a superb quality of life and is close to year-round recreation. Academic experience desirable. Resume to: Donald J Welter, MD, Professor and Chairman, Department of Family Practice, The Medical College of Wisconsin, 610 N 19 St, Milwaukee, Wis 53233. The Medical College of Wisconsin is an equal opportunity/affirmative action employer. Applications will be accepted until position is filled. 7-9/79

FIFTY PHYSICIAN MULTIspecialty clinic in western Wisconsin wants family practitioner to work in nearby satellite offices. Excellent cultural, educational and recreational facilities. 90 miles from Minneapolis. Please contact G E Owen, MD, Midelfort Clinic, Ltd, 733 W Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5222. 7-10/79

KNOXVILLE — PSYCHIATRIST —excellent professional opportunity, large Neuropsychiatric hospital, immediate vacancies for Board Certified/Eligible Psychiatrists. Strong support staff and facilities. Enjoy benefits of 30 days paid vacation, 15 days paid sick leave (accumulating) per annum; liberal retirement plan; health and life insurance; malpractice shelter; moving expenses paid; HIGHLY COMPETITIVE SALARY to $50,000 with qualifications, license in any state. Contact: Chief of Psychiatry, VA Medical Center, Knoxville, Iowa 50138; phone: 515/842-3101, ext 216. EOE. 7-9/79

3-4 BOARD ELIGIBLE/CERTIfied FPs needed in northeast rural Wisconsin. New clinic adjacent to fine 60-bed hospital. Financial assistance available and negotiable. Excellent location, community atmosphere and economy. Contact J Schumacher, Admin, Calumet Memorial Hospital, Chilton, Wis 53014. Phone: 414/849-2386. 7-9/79

MILWAUKEE, WISCONSIN Emergency Department Physician—Ground floor opportunity for Emergency Department Practice at modern 300-bed teaching hospital; flexible rotating scheduling; excellent remuneration; paid professional liability insurance; Emergency Department experience preferred or postgraduate training. Send CV to Dept 468 in care of the Journal or call toll-free 1-800-325-3982 for details. 7tfn/79

RADIOLOGIST — BOARD CERtified is needed to become the fifth associate in an active radiology practice. One or two years experience desirable. Call 715/842-0624, or write W Mahony, MD, Radiology Associates of Wausau, SC, 425 Pine Ridge Blvd, Wausau, Wis 54401. 6tfn/79

FAMILY OR GENERAL PRACtitioner: One or more to serve the City of Sheboygan Falls. Office space available. Hospitals within 5 miles. Great opportunity, over 5,000 people in progressive community without a full time physician. Write to: Sheboygan Falls Chamber of Commerce, PO Box 1, Sheboygan Falls, Wis 53085. p9-10/79

BOARD CERTIFIED OR ELIGIble primary care internists and family practitioners wanted for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel:414/289-5910. 9-12/79

WANTED: GENERAL SURgeon, orthopedic surgeon, urologist, and ENT physician to join a group of nine family practitioners, one general internist in a rural community in northeastern Wisconsin. For additional information, contact Lloyd Cotts, MD, Rice Lake, Wis. Tel: 715/234-9031. 8-10/79

WANTED—URGENT CARE physician to handle walk-ins and some occupational medicine for 25 physician clinic in east-central Wisconsin. For more information send curriculum vitae to Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935. 8-9/79

GROUP HEALTH COOPERAtive of south Central Wisconsin. A growing federally qualified staff model HMO—is recruiting family practitioners for January 1980. Excellent salary, pension and benefit program in an area of natural beauty make living and working here very attractive. Write or call David S Grab, MD, Medical Director, 1 South Park St, Madison, Wis. Phone 608/257-9700. An Equal Opportunity Employer. 7-12/79

RACINE MEDICAL CLINIC, SC, multispecialty group of 18 physicians has a practice association for

- Internist
- Obstetrician-Gynecologist
- Family/General Practitioner

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 7tfn/79

INTERNIST—THIS IS A FINE opportunity to join a five-man, well established, internal medicine group with both downtown Milwaukee and suburban offices for someone either in solo practice or completing residency. Excellent starting salary, fringe benefits, hospital associations, and teaching appointments. Please send curriculum vitae to Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 8-11/79

EMERGENCY ROOM PHYSIcian needed: Fox River Valley. 32-hour week, $80,000 plus. Includes many fringes. Send resume to Box 1424, Green Bay, Wis 54305. Tel: 414/855-6159. 8-9/79

CAREER ORIENTED ER PHYsician needed immediately in southeastern Wisconsin city of 80,000 on Lake Michigan between Chicago and Milwaukee. Multispecialty backup. Excellent nursing staff. Starting salary in excess of $70,000 per year based on 42-hour week. Send CV to Emergency Room Associates, 7743 Third Ave, Kenosha, Wis 53140. 8-10/79

FAMILY PRACTICE, ENT AND Internal Medicine positions available with a 15-man multispecialty group corporate practice. Modern clinic facility in northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 8-11/79

GENERAL PRACTICE AVAILable. One or two doctor group. Location downtown, city of 5,000. New hospital. Arrangement can be made accordingly to take over practice and equipment. Contact Dept 469 in care of the Journal. 8-9/79*

WISCONSIN — FAMILY PRACtice physician wanted, incorporated clinic group of five, including Family Practice and General Surgery. Ideal town in northern Wisconsin, 35 miles from Minneapolis. Income guaranteed first year. Contact J Craig, New Richmond Clinic, SC, New Richmond, Wis 54017 (715)/246-6911). 7-11/79

WANTED MEDICAL SPECIALties — small town between Milwaukee and Chicago serving a shopping area population of 50,000. Has 140-bed hospital, 14 GPs, 3 OB/GYNs, 1 ophthalmologist and 1 orthopedic surgeon. Custom built office space in superbly located new building. For full details contact Arthur L McCourt, 148 S Pine St, Burlington, Wis 53105. Tel: 414/763-7697. 4-9/79

PRIMARY CARE PHYSICIAN needed to join established and expanding semi-rural primary care center located within 20 miles of Madison, Wisconsin. Two additional PRIMARY CARE PHYSICIANS needed by summer 1980 for newly developing center also located within easy drive of Madison. A professional advisory group, Health Care Associates, provides management and support services with emphasis on problem-oriented system. Minimum compensation guarantee and opportunity to purchase practice within two to five years. Send curriculum vitae to J M Nelson, MD, 202 South Park St, Madison, Wis 53715. Tel: 608/267-6320. 8-10/79

FAMILY PRACTITIONERS. Good opportunity for one or two family practice physicians to join a well established three-man clinic (includes surgeon). Present staff leases modern, up-to-date, ten-year old clinic from city. Unlimited potential in a setting suited for aggressive, progressive physicians like yourself. JCAH hospital physically attached to 175-bed nursing facility. Receiving consultant specialty visitation services via the University of Minnesota in areas of Otolaryngology, Pulmonary Medicine, Neurology, Cardiology, Urology, and Internal Medicine. Located in heart of state's finest goose hunting area, fishing and lake cabin life a stone's throw away. Good schools; quiet community, with slow pace of living that includes our own cultural affairs building for staging local drama and musical activities. Are you interested enough to find out more about us? If so, contact Mr Richard L Range, Admin, Madison Hospital Association, 820 Third Ave, PO Box 184, Madison, Minnesota 56256, or call collect 612/598-7556 (office) or 612/598-7974 (home). 9-11/79

PEDIATRICIAN TO JOIN 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

WANTED: GENERAL SURgeon, board certified or eligible, preferably with some thoracic surgery interest and experience, but not essential. To join another young general surgeon in a 26-member multispecialty group in a central Wisconsin town of 35,000 with a drawing area of approximately 150,000. Community is located on a lake and 70 miles to Milwaukee, Madison, or Green Bay. 300 bed hospital. Negotiable salary guarantee. Contact Dr John Elliott, Fond du Lac Clinic, SC, Fond du Lac, Wis 54935. 9/79

FAMILY PRACTITIONER TO join three man group. Central Wisconsin community of 10,000 with drawing area of 20,000. Hundred bed accredited hospital. Handsome salary first year with many fringe benefits, full partnership second year. Send curriculum vitae to Merrill Medical Associates, SC, 716 East Second St, Merrill, Wis 54452. Tel: 715/536-2463. 9/79

NEUROLOGIST WANTED — Clinical Neurologist wanted to practice in conjunction with a 6-member Internal Medicine Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 470 in care of the Journal. 9tfn/79

FIFTY-MAN MULTISPECIALTY group has an immediate opening for:

- Orthopedic Surgeon
- Ophthalmologist
- Family Practice
- Psychiatrist

Excellent starting salaries with all fringe benefits. Monroe is a very stable economically-strong community of 10,000 located 45 minutes from Madison and 90 minutes from Milwaukee. If interested, please contact T E Peters, MD, The Monroe Clinic, Monroe, Wis 53566. 9-12/79, 1-2/80

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency

9tfn/79

Physicians Exchange

continued

OB-GYN WANTED — TO PRACtice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

Medical Facilities

SPACE AVAILABLE IN NEW professional building located 25 miles from Milwaukee in Delafield. Only 10 minutes from Oconomowoc hospital and 15 minutes from Waukesha hospital. Easy access to I-94. Design your own floor plan on the ground level. Call 414/276-0431 or 414/392-9401. 9/79

FOND DU LAC FACILITY. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

MEDICAL SUITE AVAILABLE, first floor, 1200 sq ft including reception area, 3 examining rooms, consultation room, lab, 2 bathrooms. Adjacent to Villard Pharmacy, 54th and Villard, Milwaukee, Wis 53218. Phone 414/461-2155 or 414/352-0135. 8-9/79*

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOR SALE: ULTRASONIC therapy unit. Burdick model UT-1, No v-101-Serial 1965, watts 20 per square cm. Contact Mrs Long, 2435 W Greenwood Rd, Glendale, Wis 53209. g6tfn/79

WANTED: USED X-RAY EQUIPment, accessories, ultrasonic and diathermy equipment. Call 414/444-7125. 5tfn/79

FOR SALE: PHYSICIANS EXAM table. Excellent condition. $250.00. Call: 414/494-5231 or write to: San Luis Manor, Attn: Mrs Vi Van Rooy, 2305 San Luis Place, Green Bay, Wis 54304. 9/79

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1979 Wisconsin

Oct 8-10: *Applied Immunology in Clinical Medicine,* American College of Physicians Postgraduate Course, Medical College of Wisconsin, Pfister Hotel, Milwaukee. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa.

Oct 10: *Neurology Update,* sponsored by Theda Clark Regional Medical Center in cooperation with Merck, Sharp & Dohme and Armour Pharmaceuticals, at Valley Inn, Neenah. Faculty: Michael P McQuillen, MD, professor and chairman, Dept of Neurology, Medical College of Wisconsin, Milwaukee; H Abdul Majid, MD, neurologist, Fox Valley Necrological Associates, Neenah and Appleton; Michael Rieder, MD, neurologist, Fox Valley Neurological Associates, Neenah and Appleton; Marc A Letellier, MD, neurosurgeon, Fox Valley Neurological Associates, Neenah, Oshkosh, and Appleton; and Timothy Flaherty, MD, radiologist, Theda Clark Regional Medical Center, Neenah. Meets criteria for 6 hours in Category I of PRA-AMA. Also WAFP has approved this program for 6 credit hours. Registration: $18 by October 1. Send to Paul B McAvoy, MD, Theda Clark Regional Medical Center, 130 Second St, Neenah, Wis 54956. (414/725-7071).

Oct 13-14: *Advanced Cardiac Life Support,* Wisconsin Chapter, American College of Emergency Physicians in cooperation with the American Heart Association. Milwaukee, Wis. 12 hrs Category I PRA-AMA. Fee: $150. Info: Gary Gerschke, MD of Emergency Medicine, Columbia Hospital, 2025 East Newport, Milwaukee 53211. Tel: 414/961-3508.

Oct 15-16: *Neurologic Aspects of Pediatric Disease,* Playboy Club and Resort, Lake Geneva. (Further details appear elsewhere in this section.)

Oct 17: One-Day Seminar for Family Physicians, Bellin Memorial Hospital, Green Bay.

Oct 17-19: Seminar/Workshop on Genitourinary Radiology, The Olympia, Oconomowoc. Approved for Category 1 credit of PRA-AMA. Info: Lyn Opelt, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Oct 18-20: *Evoked Potentials: Basic Principles and Practical Application,* sponsored by the University of Wisconsin-Extension, Department of Continuing Education and Clinical Neurophysiology, Department of Neurology, School of Medicine, University of Wisconsin-Madison, at UW-Madison. Lectures, panels with case presentations, and workshops for physicians and technologists. Fee: Technician one-day course (Oct 18), $50; Technician three-day course, $75; Physician two-day course (Oct 19-20), $150. Further info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

Oct 19-20: 23rd Annual Clinic Day Program: Colorectal Carcinoma: Medical and Surgical Aspects of Diagnosis and Treatment. Approved for 6 hrs Category I CME/AAFP credit. Info: Medical Education Office, St Joseph's Hospital, 5000 W Chambers St, Milwaukee, Wis 53210.

Oct 20: *Second Annual Northwoods Colorama Retreat,* sponsored by the University of Wisconsin-Extension, Department of Continuing Education; Eagle River Memorial Hospital, Eagle River; and Northwoods Hospital, Phelps, at Northland Pines High School in Eagle River. Lectures, discussion and workshops for physicians, emergency medical technicians, and nurses. Fee: Physicians, $25; EMTs, $15; and Nurses, $15. Further info: Sarah Z Aslakson, CME, 465 WARF Bldg, 610 Walnut St, Madison, Wis 53706.

Oct 26-27: Pharmacology and Therapeutics for the General Doctor, sponsored by the University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin-Madison, School of Medicine; and Wisconsin Chapter, Academy of General Dentistry, at the Wisconsin Center in Madison. A lecture, discussion, panel format for dentists. Fee: $65. Football tickets for Wisconsin/Iowa game are reserved for participant purchase. Further info: Sarah Z Aslakson, CME, 465B WARF Building, 610 Walnut St, Madison, Wis 53706; phone 608/263-2850.

Oct 30-Nov 2: *Employee Assistants Program Conference,* Olympia Inn, Oconomowoc, Wis. Info: Frank Wenc, Assistant Professor, University of Wisconsin Extension, Center for Social Services, 322 Lowell Hall, 610 Langdon, Madison 53706. Tel: 608/262-2351. Further details appear elsewhere in this section.

CARDIAC REHABILITATION

One to Two Week Workshops

October 8-19, 1979

April 9-20, 1980

Workshop Unit—LaCrosse Exercise Program

University of Wisconsin-LaCrosse

Director: Philip K Wilson

Cost: First week (didactic lecture structured laboratory experience)—$350. Second week (optional staff participant involvement)—$200.

Contact: Workshop Unit—LaCrosse Exercise Program, Mitchell Hall, University of Wisconsin-LaCrosse, LaCrosse, Wis 54601.

Phone: 608/785-8686

Neurologic Aspects of Pediatric Disease

Playboy Club and Resort Lake Geneva, Wisconsin

Oct 15-16, 1979

Sponsored by The Medical College of Wisconsin and Milwaukee Children's Hospital

Guest faculty:
William E Bell, MD
Bernard J D'Souza, MD
Norman Fost, MD
Gerald P Koocher, PhD
John M Opitz, MD
N Paul Rosman, MD

Approved for 14 hrs of Category I credit of PRA-AMA and AAFP.

Info: Ms Jennie M Evenson, Dept of Neurology, The Medical College of Wisconsin, Milwaukee Children's Hospital, PO Box 1997, Milwaukee, Wis 53201. Tel: 414/931-4074.

NUCLEAR CARDIOLOGY: Principles and Applications

Fourth annual nuclear cardiology symposium sponsored by Mount Sinai Medical Center, Milwaukee

Wed-Sat/October 10-13
Red Carpet Inn, Milwaukee

Cosponsors: Cardiovascular Life Sciences Program of the University of Wisconsin-Madison School of Medicine; Department of Continuing Medical Education of the UW-Extension Health Science Unit; American Heart Association-Wisconsin Affiliate; and Society of Nuclear Medicine.

Donald H Schmidt, MD, UW School of Medicine professor, will chair the symposium as he has for the past three years. Doctor Schmidt is head of the Cardiovascular Disease Section at Mount Sinai Medical Center.

Symposium faculty include: Michael L Goris, MD, PhD (Stanford); Richard L Gorlin, MD (Mount Sinai Medical Center, New York City); Glen W Hamilton, MD (VA Hospital, Seattle); W Turner Harris, MD (Univ of Arkansas); B Leonard Holman, MD (Peter Bent Brigham Hosp, Boston); W Dudley Johnson, MD (Mount Sinai Medical Center, Milwaukee, and Medical College of Wisconsin); Robert H Jones, MD (Duke); William J MacIntyre, PhD (Cleveland Clinic); Melvin L Marcus, MD (Univ of Iowa); Richard N Pierson Jr, MD (St Luke's Hosp, New York, and Columbia Univ); P Rentrop, MD (Univ of Goettingen, West Germany); Robert Slutsky, MD (San Diego, Univ of California); H William Straus, MD (Harvard); Eugene D Van Hove, MD (Methodist Hosp, Indianapolis); and Robert A Vogel, MD (VA, Denver).

Serving with Doctor Schmidt on the program committee are Charles K Hellman, MD, assistant professor of medicine in the cardiovascular disease section of the University of Wisconsin School of Medicine and Mount Sinai; Fred M Blau, MS, an instructor in the CDS; and John G Carpenter, chief technologist in the nuclear cardiology department at Mount Sinai.

Physicians and nuclear medicine technologists from around the country will be in attendance. More than 150 people have attended each of the three previous conferences.

Further info:
Mount Sinai Medical Center
950 North Twelfth Street
Milwaukee, Wis 53233
Telephone: 414/289-8026
Contact: Richard Pearl

The Eighties and Beyond:

Perspectives on the Future of American Medicine

WAUSAU CLUB, 309 McCLELLAN ST, WAUSAU

Saturday, September 29, 1979

PROGRAM

9:00- 9:25 **The Health Care System—From Fibrillation to Synergism**
Earl Thayer, Executive Secretary, State Medical Society

9:25- 9:50 **Cost Containment and Certificate of Need—Management or Meddling**
Donald Percy, Secretary Wisconsin Department of Health and Social Services

9:50-10:15 **Lessons from the Canadian Experience**
Charles Birkett, MD, Consultant, Hickling- Johnson Ltd., Toronto

COFFEE & DANISH

10:35-11:00 **HMO's—A Passing Fancy or Wave of the Future**
Jacob Spies, Professor of Medical Economics, Boston University

11:00-11:25 **The Physician As a Political Activist—Options and Opportunities**
Darold Treffert, MD, President, State Medical Society

11:25-11:40 **Point/Counterpoint**
James Kimmey, MD, Executive Director, Midwest Center for Health Planning
JD Kabler, MD, President, Dane County Medical Society

LUNCHEON

1:00- 1:25 **Promoting the General Welfare, Can We Afford It?**
David Obey, Congressman, Wisconsin Seventh District

1:25- 1:50 **National Health Insurance: The Political Realities**
Lowell H. Steen, MD, Chairman of the Board, American Medical Association
REFRESHMENTS

2:15- 4:00 **Panel Discussion, Question & Answer Session**
Earl Thayer, Moderator

Sponsored jointly by

Marathon County Medical Society
Wausau Insurance Companies
State Medical Society of Wisconsin

The cost of this one day program is fifteen dollars, which will cover the cost of refreshments, luncheon and the open bar. Please make check payable to the Marathon County Medical Society and mail to: Leonard H Wurman, MD, Meeting Coordinator, Ear, Nose & Throat Associates of Wausau, SC, 425 Pine Ridge Boulevard, Suite 305, Wausau, Wisconsin 54401

1979 Others

Oct 1-4: American College of Emergency Physicians, Hyatt Regency, Atlanta, Ga. Info: A E Auer, 3900 Capital City Blvd, Lansing, Mich 48906.

Oct 5-7: Michigan Regional Meeting of American College of Physicians, Boyne Highlands Lodge, Harbor Springs, Mich. Info: Boy Frame, FACP, 543 Lakepointe, Grosse Pointe Park, Mich 48230.

ONE-DAY SEMINAR FOR FAMILY PHYSICIANS

Bellin Memorial Hospital
Green Bay

Wednesday, Oct 17, 1979

A Day of Anemia & Chemotherapy

Program
am
10:00—Iron Deficiency & Other Microcytic Anemias, *James V Lacey, MD*, Green Bay

Hemolytic Anemia, *Anthony V Pisciotta, MD*, Milwaukee

1:00—Laboratory Tests in Patient Management (Emphasis on Breast Cancer), *Guillermo Ramirez, MD*, Madison

Practical Techniques For Chemotherapy (Breast Cancer; Testicular Cancer), *Paul D Koch, MD*, Green Bay

St Vincent Hospital, Green Bay

Wednesday, Nov 14, 1979

Orthopedics & Emergency Treatment

10:00—The Painful Shoulder Syndrome, *H A Tressler, MD*, Green Bay
Rheumatoid Arthritis Versus Osteoarthritis, Diagnosis & Treatment, *David H Bartlett, MD*, Madison

1:00—CRP — Basic Review, *William A Forkner, MD*, Sheboygan

Emergency Treatment of the Common Life Threatening Arrhythmias, *Robert T Block, MD*, Green Bay

Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

1979 Others

Nov 7-11: American Medical Women's Association, Albuquerque Hilton, Albuquerque, NM. Info: L Loesel, 1740 Broadway, New York, NY 10019.

Nov 19-23: Advanced Concepts in Diagnostic Imaging, sponsored by General Electric Company's Medical Systems Division, at the Maui Surf Hotel, Maui, Hawaii. Course is specifically designed for healthcare professionals; it will provide a concentrated presentation of advanced concepts in computed tomography, ultrasound, radiology, and nuclear medicine. Topics to be emphasized include quantitative and qualitative applications of factors enhancing diagnostic accuracy and cost containment in diagnostic imaging. For registration information, contact Charles H Rose, director of Medical Education, PO Box 414 (TI-40), Milwaukee, Wis 53201.

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Lose your license?

You could . . . if you fail to report your continuing medical education credits to the State Medical Examining Board by December 1, 1979. State law requires all licensed physicians to submit proof to the Board of 30 hours of Category I continuing medical education credit. Any physician failing to report CME credits by December 1, 1979 will not receive a license renewal notice for 1980-81.

Category I CME credits accumulated since January 1, 1977 can be reported. A receipt from the sponsoring organization indicating its name, your name, the number of hours completed, and Category I approval by either the AMA or the AOA is required. Proof of CME credits must be sent by December 1, 1979 to:

State Medical Examining Board
1400 East Washington Avenue
Madison, Wisconsin 53703

. . . or you won't have a license to practice medicine in 1980. If you have questions or concerns, call the State Medical Society Health Services Division: 608/257-6781 (Madison area) or toll-free 1-800/362-9080. ■

Second Annual Conference
EMPLOYEE ASSISTANCE PROGRAMS II

October 30-November 2, Olympia Inn, Oconomowoc

Sponsored by: University of Wisconsin-Extension, Center for Social Service; Wisconsin Dept of Health and Social Services in cooperation with 36 contributing agencies.

Tuesday, Oct 30: Panelists will discuss basic Employee Assistance Programming (EAP) concepts, terminology, and provide a basic program design. Participants who have minimal experience, or anticipate developing an EAP program are encouraged to share in this event.

Wednesday, Oct 31: EAP-II officially opens. The purpose of this day is to identify and to address issues related to the following topical program areas: Executives; Health Professionals; Judicial; Public Service; Students and Faculty; Supervised and Hourly Personnel; and Unsupervised Personnel. Featured speakers are: *Governor Lee S Dreyfus; Dr Russell Smith; Mr John McManus,* and *Mr Tim Hoare.*

Thursday, Nov 1: Topical concerns, self-satisfaction and modifying stressful work environments in the context of Employee Assistance Programming. Featured speakers are: *Jane Parker, RN; Dr Hannibal Williams,* and *Dana Andrews.*

Friday, Nov 2: Summary of program. Wisconsin Annual Employee Assistance Award Presentation: *Mr Wilbur Walter,* Wisconsin AFL/CIO will receive the Award on Behalf of Organized Labor.

SMS members participating in the program are:

- *William Freeby, MD,* Vice-president and Medical Director, Aid Association for Lutherans
- *George Handy, MD,* Vice-president and Medical Director, CUNA Mutual Insurance Society
- *Roland Herrington, MD,* Medical Director, DePaul Rehabilitation Hospital
- *Don Johnson, MD,* Assistant Medical Director, Sentry Insurance

Application has been made for CME credit.
Info: Mr Frank Wenc, Assistant Professor, University of Wisconsin-Extension, Center for Social Service, 322 Lowell Hall, 610 Langdon St, Madison, Wis 53706. Tel: 608/262-2351.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

You can't refuse to administer a chemical test, including a blood test, when asked by a law enforcement officer. Wisconsin Attorney General LaFollette recently issued this opinion:

> Under the Implied Consent Law, sec 343.305, Stats, hospitals must comply with the request of a law enforcement officer to administer chemical tests including a blood test. This assumes that the **driver has not withdrawn** his or her consent to submit to that test. **Drivers who are unconscious or otherwise incapable of withdrawing their consent are presumed not to have withdrawn it.** The **refusal of** hospitals, **physicians,** nurses, and other health professionals authorized to withdraw blood to comply with such request **constitutes the refusal to aid an officer** within the meaning of sec 946.40, Stats. In complying with the request, the professional incurs no civil or criminal liability, except for any negligence in the course of compliance. The person performing the chemical test must report the findings to the Department of Transportation, the law enforcement agency, and the individual involved. Failure to report to the law enforcement agency also constitutes the refusal to aid an officer within the meaning of sec 946.40, Stats.

Don't believe what you read in the papers to the effect that a new law is needed to give patients the right to inspect their medical records. Despite Senator David Berger's (Milwaukee) introduction of bill S-260 to give patients the right to their medical and dental records, the fact is that present state law clearly requires physicians to comply with patient requests to inspect and copy their treatment records. SMS has advised physicians for 20 years that Wisconsin law [current section 804.10 (4)] requires such inspection and copying upon written authorization. See *WMJ,* June 1979, pp 23-26.

Prohibit advance payment for services? That is being considered in the Legislature. Asking a patient to pay something in advance on services not yet performed has important doctor-patient or public relations implications. What about the ethics? In response to this question, Darold A Treffert, MD, President of SMS, recently issued the following statement:

> The State Medical Society supports that principle of medical ethics which in part declares that "a physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged, he may discontinue his services only after giving adequate notice."
>
> The physician-patient relationship is and should continue to be strictly a matter of choice on the part of patient and physician if the best interests of the patient are to be served. It is the position of the Society that a physician has a duty to take care of an individual in an emergency situation without regard to fee or ability to pay. Any failure to do so in an emergency circumstance does constitute unprofessional conduct, in the Society's opinion.
>
> However, the Society seriously questions the feasibility or desirability of prohibiting in every non-emergency situation an arrangement between a patient and a physician for advance full or partial payment of fees for certain services. For example, situations involving elective procedures such as cosmetic surgery or psychiatric counseling, or advance planning for the delivery of a child, might very well indicate some payment of fee prior to completion of the services. Such arrangements, clearly stated, could hardly be considered unprofessional conduct. In fact, they may contribute to better understanding between patient and doctor.

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WISCONSIN MEDICAL JOURNAL

OCTOBER 1979

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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President's Page

Darold A Treffert, MD

The amphetamine ban . . . . . a success story

In my acceptance speech as President of the State Medical Society, I indicated that one thing medicine must do, as part of its image, is to highlight its successes. One such success is the manner in which the medical profession in Wisconsin solved the licit amphetamine diversion problem in the state. Wisconsin has set the lead for other states; the federal government itself is now following that lead. It is nice to be proactive for a change, rather than merely reactive, and to shape policy, rather than merely be shaped by policy.

In March 1976 the Controlled Substances Board of Wisconsin, of which I am the psychiatrist-member and chairman, learned that over one million doses of a single amphetamine—Biphetamine® 20—were being prescribed in Wisconsin and many of these legitimately manufactured and prescribed pills were ending up on the street for sale as "black cadillacs." There were, in fact, clinics and physicians' offices in the state where prescriptions, and not services, were for sale. In spite of the general medical consensus that the clinical usefulness of amphetamines was narrow indeed—limited to the treatment of narcolepsy and hyperkinesis in children (both rather rare conditions)—literally millions of doses of Schedule II amphetamines were being prescribed and dispensed in the state. Some Title 19 patients were purchasing amphetamines using their card to pay for the doctor's visit, having the prescription filled, also courtesy of Title 19, and then selling the drug on the street at huge profits. This became a livelihood for some in what was a no-overhead operation.

Even more startling was the revelation that of the 118,300 doses of Biphetamine® 20 directly dispensed by practitioners (MD, DO, DDS, and DPM), 71% of those doses were dispensed by only 5 of the 9,500 licensed practitioners in Wisconsin; of the total 10,212 prescriptions in 1975 for Biphetamine® 20 alone, as few as 8 practitioners were responsible for 82.7% of those prescriptions.

Following the receipt of that information, the State Medical Society Council, acting on recommendation of its peer review committee, approved a statement on June 14, 1977 setting forth those conditions for which amphetamines were acceptable, probably acceptable, and rarely acceptable. Using that as a guide, the Medical Examining Board of Wisconsin promulgated a policy that defined as "unprofessional conduct" the prescribing or dispensing of amphetamines for any purpose other than five very limited indications.

That policy, again using SMS input, was developed and set forth as follows:

> "Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine or sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch 161 *Wis Stats* to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun."

The new amphetamine policy took effect on Nov. 1, 1977. There was an immediate drop in amphetamine sales; that drastic drop has continued and there has been no sizable increase in sales or diversion of Schedule III or IV substances. Sales of Biphetamine® 20, for example, dropped from 27,000 doses (270 bottles of 100) monthly to 700 doses (7 bottles of 100) monthly in January 1978. This is a drop of 97% of this single product and this drastic drop is mirrored as well in sales of Eskatrol® and Preludin®, for example. Corresponding to this dramatic drop in amphetamine sales, there has been a parallel drop in amphetamine arrests confirming the impression

that curtailing supply is reflected in less criminal activity with respect to that particular product. Wisconsin ranked 28th in the nation for licit amphetamine availability in 1976. When the 1977 figures are released, it is expected Wisconsin will have dropped to 51st, last on the list—a good distinction for which *not* to be number one.

There are few situations in clinical practice where cause and effect of a policy can be so quickly, definitively, and dramatically seen as in this instance. The state health at large is none the worse for having two million doses of amphetamines less in it; the citizenry is none the fatter I would submit; and no practitioner or patient truly in need of amphetamines for one of the very limited indications is being deprived of the drug for those purposes.

In the matter of public policy making, that's probably as good as it gets. And the Wisconsin medical profession played a generous, and pivotal, role in that successful scenario.

A success story. ■

OPERATION LIFESTYLE

It's something all of us lead. It can make the difference in our day-to-day ability to cope. It affects how we feel about other people and how we feel about ourselves. What is it? . . . It's our lifestyle — our unique patterns of daily activity. Physicians and their patients can become acquainted with how lifestyle habits can preserve and increase their physical and mental well-being by taking a 30-minute television quiz "Operation Lifestyle." "Operation Lifestyle," a cooperative project of the State Medical Society of Wisconsin, the Wisconsin Educational Network, and the Wisconsin Department of Public Instruction, will be broadcast Thursday, October 25, at 8:30 pm and repeated Monday, October 29 at 10:30 am for use in schools on Channels 38/Green Bay, 36/Park Falls, 31/LaCrosse, 28/Menomonie, 20/Wausau, 21/Madison, and 10/Milwaukee. ■

MEDICAL EXAMINING BOARD

In mid-August, the Medical Examining Board erroneously mailed letters to certain Wisconsin physicians informing them that they had not met the full continuing medical education requirement for 1980-81 relicensure. Some of these physicians **had indeed** met the requirement, but the Board's computer had not yet programmed their credits. All physicians who have received letters since January 1, 1977 from the MEB stating that they have fulfilled the CME requirement should **ignore** the mid-August letter.

If, on the other hand, a physician has not received a letter stating that he or she has completed the CME relicensure requirement, that physician must complete and report 30 hours of Category I continuing medical education credit to the Medical Examining Board by December 1, 1979. Any physician failing to report CME credits by this date will not receive a license renewal notice for 1980-81.

There are **no** exemptions from CME requirements for physicians. Even those physicians exempt from malpractice insurance requirements in Wisconsin must fulfill the above CME requirement. Furthermore, physicians who have completed at least three months of their residency since January 1, 1977, have fulfilled the 1980-81 CME requirement provided that the residency training program has sent a letter to the Board informing it of this fact.

BOARD ACTIONS:

The Medical Examining Board has revoked the license of James Zarzynski, MD of Eau Claire and Milwaukee, stayed the revocation and limited his license for five years. The Board found that because Zarzynski was addicted to cocaine and exhibited psychological impairments he could not practice medicine with reasonable skill and safety to patients.

The Board has revoked the license of Kwoh Cheng Sun, MD, of Siren since Sun violated Wisconsin law when he was convicted in Michigan of unlawful delivery of controlled substances and counterfeit substances. ■

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841

Representing 4,700 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

Where have all the doctors gone?

It becomes increasingly apparent in the publications of the American Hospital Association, that the role of a physician in shaping hospital policy has been sharply reduced. The magazine, *Trustee,* published by the American Hospital Association, in its report on the summer meeting entitled "Second Annual AHA Conference on Hospital Governance," outlines a broad syllabus of the future of voluntary private hospitals in the United States. The story was about PhDs, "hospital consultants," and chairmen of lay boards of directors. Buzz words like "CEO" (chief executive officer), "marketing surveys," and "community outreach" populate the resume of this meeting. Health education for the general public is now deemed to be one of the functions of a hospital in need of greater emphasis. Policy making decisions are no longer a province of the medical staff of a hospital but of management consultants, demographers, market analysts, and PhD health administrators.

The American Hospital Association meeting in Kansas City emphasized points that seem far removed from the mainstream of medicine. Chiefly, they are concerned that "the medical staff organization and its individual members will become further integrated into the hospital's corporate structure." Also, "smaller and more professionalized boards will be developed whose members will be compensated for their services."

Other points emphasized in the summer meeting were "find out what people want and give them more of that, find out what people don't want and give them less of that;" and "the headset of the industry has to be shifted to consumers." Other thoughts by the assemblage included "understand that communication is a responsibility of the hospital—and a job for the pros."

What all of this apparently means is that "health care is too important to be trusted to doctors." It is all part of the theme that hospital costs are outrageously high and that the medical system has been badly bungled under the physician's direction. With a little management at the top, most of the excesses of hospital costs could be eliminated by a battery of able executives, informed hospital trustees, consumer advocates, and health planning agencies.

At a time when everything hospitals purchase show the effects of national inflation, hospitals should logically be expected to hold the line on costs by skillful management. In light of the increasing layers of federal regulations burdening the hospitals, approximately $38.00 per day of per diem costs can be directly attributable to federal and state regulations. The hospital plant size in the United States is so enormous and has been built to such a high level of excellence that it is the envy of all the other nations in the world. Now having achieved this preeminent state, it is time for medical professionals to turn the entire edifice over to the MBAs, CEOs, and marketing analysts. The enormously complex and effective medical system in the United States is now referred to as an industry. Since most physicians do not regard themselves as industrialists, perhaps this can explain where all the physicians have gone.—RAM

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Snap, crackle and pop

A news clip in a July issue of the SMS Medigram reported an article from the *Milwaukee Sentinel.* In this article from Appleton, a child was quoted as saying that she nicknamed her chiropractor the "Popcorn Doctor" because of the cracking sounds her back made during an adjustment. The same article quoted a chiropractor as saying that he checks the spines of newborn babies and corrects any problems with a simple adjustment that puts the vertebrae into their normal position.

Following are a number of direct quotes from a column entitled "You And Your Health!" written by a Wisconsin chiropractor for publication in state newspapers:

> "It is a law of nature that when the body is out of balance and the spinal vertebrae and discs are subluxated, discomfort, pain and illness can result. Whatever your health problem may be, don't let

painkillers delay proper treatment. Consult a chiropractor. He will look for the underlying cause of the problem, and if he finds that yours is a chiropractic case he will give you the help needed."

"As a specialist in nerves and spinal disorders, the doctor of chiropractic knows that nerve interference in the low back is the actual cause of the problem. (Sciatica). His training and experience enable him to treat the cause, not just administer temporary measures aimed at relieving the symptoms. With the nerve interference eliminated, the sciatic nerve can once again function properly, eliminating the pain and discomfort naturally from within."

"Whiplash is a type of injury that requires the special knowledge, experience and skill available through chiropractic. Without proper care and understanding, severe or permanent damage may result. The most serious consequences are the results of delay in getting proper treatment. If you are the victim of a neck injury, from a whiplash or any other cause; and if you have any of the symptoms listed; consult a chiropractor."

"The list of symptoms and ailments caused by nerve interference in the neck is truly fantastic. Some of these symptoms are: chronic headache, deep or superficial pain in the face, ears, and throat; dizziness, ringing in the ears, insomnia, extreme nervousness, irritability, tremors; shortness of breath; pain in the back and postural distortion; numbness, burning sensation, pain or 'tingling' in the arms and shoulders, and overall body aching."

"A smart general in the war against arthritis is a chiropractor. His advice, based upon training and long experience, always starts with prevention. This means a trip to his office, x-rays and diagnosis. There is no purpose in putting off a visit to a chiropractor if you even suspect that you may have arthritis. If you don't have arthritis, think of the peace of mind you will achieve. If you do have it, the sooner your case is diagnosed and treated, the better it will be for you and the less pain you will experience. Either way, putting yourself in professional hands is the sure way to peace of mind."

You will note that I have limited this presentation entirely to direct quotes. This is done intentionally in view of the spate of scattergun suits that chiropractors *and* the state of New York have filed against the American Medical Association and a dozen other defendants. Although the AMA has abandoned its blanket condemnation of chiropractic as "unscientific cult," the Board of Trustees reaffirms the traditional medical viewpoint that "the American Medical Association knows of no scientific evidence to support spinal manipulation and adjustment as appropriate treatment for human ailments such as essential hypertension, heart disease, stroke, cancer, diabetes and infections." Under the new policy the AMA will continue to warn the public of hazards of relying on spinal manipulation to treat such conditions.

There is one fundamental and irrefutable fact and that is that some 85 years ago chiropractic was founded by an itinerant tradesperson and that the chiropractic theory is unsupported by scientific evidence.—VSF ■

PROFESSIONAL ADVERTISING

A recent *Milwaukee Journal* article reported that Gov Jerry Brown of California has signed legislation permitting healthcare professionals to advertise their fees and services. The legislation enables doctors, dentists, psychologists, and pharmacists, as well as other professionals in the healthcare related fields, to advertise. ■

NURSING HOMES

An Associated Press story recently pointed out that the large majority of nursing home residents in the US are white and female. While 70 percent or 928,000 are female, only 375,000 residents are men, and 81,000 are blacks and 14,000 are hispanics. The article, citing results from a survey conducted of 1,700 nursing homes in 1977 by the National Center for Health Statistics, said the average charge to residents in 1977 was $689 a month. For nearly half, the primary source of payment was Medicaid. For one-third, their own income or family support paid the biggest share of the bills. In 75 percent of the nursing homes, the health services staff worked around the clock in three shifts. In 46 percent of these homes, registered nurses were in charge and on duty for at least two shifts. In 36 percent, licensed practical nurses were in command for at least two shifts. ■

In Perspective

BRIAN JENSEN, Director
Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

Wisconsin Health Education Loan and Forgiveness Program

EDITOR'S NOTE: *The 1979-81 State Biennial Budget contained a provision to require medical students to assume a higher portion of their education costs. The 'loan forgiveness program' would permit students to 'borrow' up to $10,000 per year to a maximum of $50,000. The 'loan' could then be 'forgiven' at the rate of $2500 per year, or 12.5%, if the student practices in an underserved area of the State. An additional $2500 per year, or 12.5%, would be 'forgiven' if the student became a 'primary-care physician.' This 'forgiveness' would be possible for up to four years. The State Medical Society Council, while endorsing the intent of the program, did not specifically react to the proposed tuition increase because of the unknown future status of federal capitation grants. The following article, by Rep Joseph Czerwinski and Sen Paul Offner, summarizes the legislative intent inherent in the program.*

* * *

WE HAVE BEEN ASKED to reflect upon the goals embodied in the Wisconsin Health Education Assistance Loan and Forgiveness Program, as well as the process through which it became law in July as part of the 1979-81 state biennial budget.

The enactment of this proposal, which we introduced, was based first upon the perception that the medical education system was not facing up effectively to the need for family practitioners and other primary-care specialists in Wisconsin. Secondly, the Legislature felt there was a discrepancy in the small proportion of instructional costs paid as tuition by medical students as compared to their expected future earnings. Third, there were doubts as to whether Wisconsin has given proper direction to its medical schools.

The questioning of the medical school's ability to address our severe distributional problems was highlighted by statistical data concerning the availability of physicians in rural Wisconsin. Data which we provided our colleagues in the Legislature showed that in northeastern Wisconsin there is one physician for every 1000 people; in western Wisconsin, the ratio is one physician for every 930 people. These figures, compared with the national average of one physician to 527 people, indicated that state policy was needed to direct the medical schools' efforts to addressing the serious problem of maldistribution.

Due largely to the phase-out of federal capitation aids (currently about $1400 per medical student), resident tuition at the UW-Medical School will increase gradually from 16 percent of instructional costs to 26 percent—from about $2400 to $5200—over the period from 1980 to 1983. Nonresident tuition and tuition at the Medical College of Wisconsin will experience a comparable increase.

In approving the tuition increase, the Legislature recognized that the enormous public subsidy of medical education is regressive in nature. The average medical student comes from a family of above-average income. As a doctor, he/she will earn a high income. Accordingly, he/she should pay a reasonable share of the costs of his/her education.

The enactment of this legislation has produced some intangible benefits: for one, it reminded the Legislature of the serious problems the State has in persuading physicians to practice in shortage areas. It provided a platform for medical students to share with legislators their concerns for the problems they perceive at the medical schools. It sent a clear message to both medical schools that they should place more emphasis on family practice and other primary-care specialties.

We do not believe that this proposal, by itself, will fully answer the serious questions concerning the distribution of physicians or the large state subsidy of medical education. We do hope, however, that the intentions of policy makers, educators, and even students, can be redirected and expanded to include other initiatives, both within, as well as outside, the educational system, that will address the questions of maldistribution and specialty choice.

In conclusion, the new loan and forgiveness program needs to be viewed as a single component in the broad effort to redirect Wisconsin's medical education policy. The creation of the Medical Education Review Committee, the establishment of the family practice programs and residency training, and now the Health Education Assistance Loan and Forgiveness Program ought to be seen as parts of a coherent policy package. In isolation, none of these initiatives would solve fully the State's maldistribution problem, but together they have a real chance of doing so.—REPRESENTATIVE JOSEPH C CZERWINSKI and SENATOR PAUL OFFNER ■

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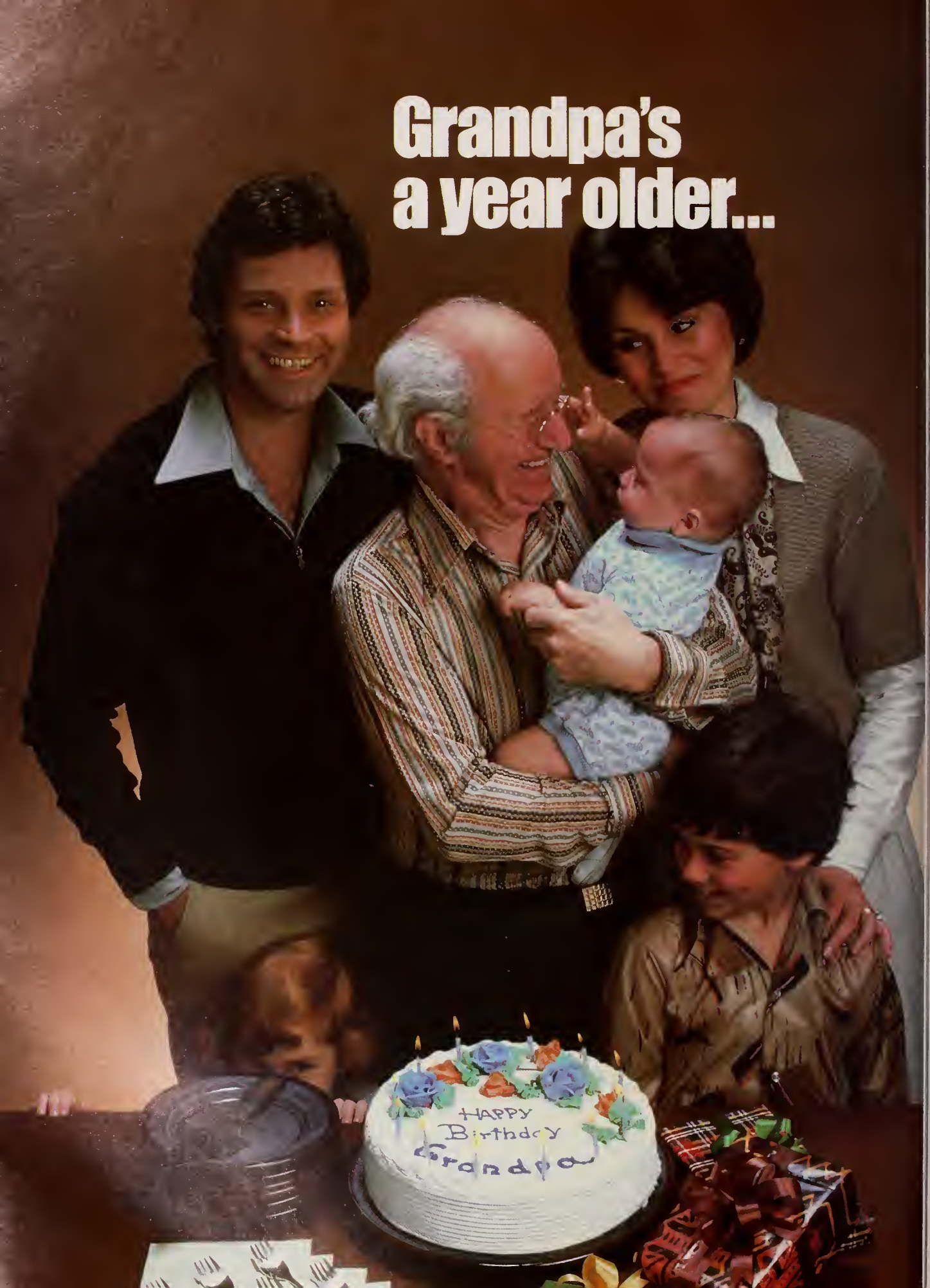

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PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. *Adverse reactions* include local erythema and soreness at the injection site; low-grade fever occurs occasionally. *PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine.* Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

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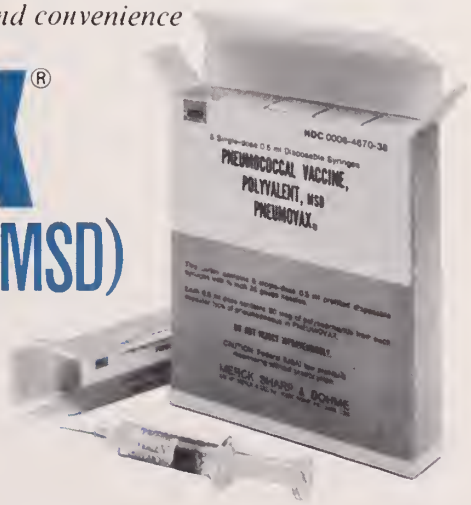

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Please see following page for summary of prescribing information.

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INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: *PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).*

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature	Pneumococcal Types													
U.S.	1	2	3	4	6	8	9	12	14	19	23	25	51	56
Danish	1	2	3	4	6A	8	9N	12F	14	19F	23F	25	7F	18C

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported.

Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe
Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials
For Syringe Use. Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

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Medical School Graduates

Where and why do graduates of the University of Wisconsin-Madison Medical School practice in Wisconsin?

Howard L Stone, PhD and **Ralph Hawley**, Madison, Wisconsin

WITH THE INCREASING concern of both consumers and healthcare providers about the distribution of health manpower and the availability of adequate healthcare to all segments of the population, these questions have become an area of increasing speculation. Although these problems may have arisen from a variety of multifaceted causes, many solutions addressing only one or several of the causes have been proposed. In addition, some of the proposed solutions are not based on accurate or updated information about graduates of the University of Wisconsin-Madison, and the quality of a proposed solution is necessarily related to the accuracy of the data upon which it is based.

The University of Wisconsin-Madison Medical School has long had an interest in documenting the practice location and specialty choices of its graduates. A comprehensive longitudinal study of medical students was begun in 1973, profiling students from the time they enter and progress through the four years of medical school, during residency training, and into practice. Although a study of this nature takes considerable time to evolve, it is interesting to note that the questions now being raised by others about what influences the medical school graduate's choice of specialty and practice location are currently being researched at the University of Wisconsin-Madison. This research, when concluded, will provide more valid and reliable prospective data than the retrospective data currently reported by most other studies.

What are the facts about recent graduates of the University of Wisconsin-Madison Medical School? The following data for the graduating classes for 1965 through 1973 are verified from the Medical School alumni records as of February 1979.

How many graduates of the University of Wisconsin-Madison Medical School stay in the State of Wisconsin to practice medicine?

1. Twenty-six percent *(26%)* of the graduates are in a primary care specialty (family practice, general practice, pediatrics, and obstetrics/gynecology).
2. In addition, *13.6%* of the graduates are internal medicine practitioners, many of whom are primary care physicians.
3. *Therefore, close to 40% of the graduates are practicing in a primary care specialty.*
4. Surgery specialty practice has been associated primarily with practice in a large community. What are the facts? For the years 1965-1973:
   —Three, or *0.9%,* of the graduates who are practicing in Wisconsin are practicing general surgery in Milwaukee.
   —Two, or *0.6%,* of the graduates who are practicing in Wisconsin are practicing orthopedic surgery in Milwaukee.
   —One, or *0.3%,* of the graduates who are practicing in Wisconsin are practicing neurological surgery in Milwaukee.

Doctor Stone is Director, Office of Educational Resources, Center for Health Sciences, and Associate Professor, Department of Continuing Medical Education, UW-Extension. Mr. Hawley is Associate Dean, University of Wisconsin-Madison Medical School. Reprint requests to: Howard L Stone, PhD, Director, Office of Educational Resources, Center for Health Sciences, UW-Madison, 1st Floor, 427 Lorch Court, Madison, Wis 53706. Copyright 1979 by the State Medical Society of Wisconsin.

What are the practice specialties of the graduates who are practicing in Wisconsin?

Table 1—Analysis of retention rates for UW-Madison Medical School graduates 1965-1973

Year of graduation	No. now in Wisconsin	Number graduated	Percent retention
1965	29	80	36.3
1966	35	85	41.2
1967	34	91	37.4
1968	31	95	32.6
1969	31	93	33.3
1970	35	95	36.8
1971	39	100	39.0
1972	33	93	35.5
1973	42	105	40.0
TOTALS	309	837	36.9

1974 ↓ 1978

Data not available beyond the 1973 graduation class. Too many students are still in residency training programs to give an accurate picture of practice retention rates.

Table 3—Practice specialties of graduates practicing in Wisconsin 1965-1973

Practice specialties	N	% of Total
Primary care	81	26.2
Internal medicine	42	13.6
Surgery	55	17.8
Referral specialties	70	22.7
Psychiatry	24	7.8
Other-Patient contact	14	5.2
Other-Health related not involving patient care	21	6.8
TOTAL	309	100.0

*Practice Specialty Clusters were adapted from Yufit RI et al: "Medical Specialty Choice and Personality," Part I, Archives General Psychiatry, 20 (1969).

Primary care
Pediatrics, obstetrics/gynecology, family practice, general medicine.

Referral specialties
Anesthesia, radiology, ophthalmology, pathology, dermatology, otorhinolaryngology.

Others-Patient contact
Cardiovascular, endocrinology, neurology.

Table 2—An analysis of the size of practice communities of UW-Madison Medical School graduates 1965-1973

Categories of size of practice communities	N	% of Total	Practice communities
0-5,000	40	12.9%	Amery, Bayside (2), Bloomer, Cameron, Chetek (3), Coon Valley, Cumberland (2), Eleva, Fox Lake, Grantsburg, Hayward, Hubertus, Ladysmith, Lancaster, Minocqua, Nashota, New Richmond, Onalaska, Oregon (2), Prairie du Sac (2), Rothschild, Schofield, Sheboygan Falls, Waunakee, Verona (2), Viroqua, Waupaca, Westby, Whitehall, Wisconsin Dells, Woodruff (3)
5,000-20,000	64	20.7%	Ashland (6), Beaver Dam (3), Burlington, Chippewa Falls, DePere, Elm Grove (4), Fort Atkinson, Fox Point (2), Germantown, Glendale, Hartford, Marinette, Marshfield (5), Menasha, Menomonie, Mequon (2), Merrill, Monona, Monroe (5), Oconomowoc, Platteville, Prairie du Chien, Rhinelander (3), Ripon (2), Shawano, Shorewood, Stoughton (2), Sturgeon Bay, Sun Prairie, Two Rivers, Watertown (3), West Bend (3), Whitefish Bay (2), Wisconsin Rapids (2)
20,000-50,000	69	22.3%	Brookfield (8), Cudahy, Eau Claire (10), Fond du Lac (5), Greenfield, Janesville (6), Manitowoc (3), Menomonee Falls (4), Neenah (5), New Berlin, Sheboygan (3), Stevens Point (5), Waukesha (4), Wausau (13)
50,000-100,000	47	15.2%	Appleton (5), Green Bay (13), Kenosha, La Crosse (16), Oshkosh (3), Racine (3), Wauwatosa (5), West Allis
100,000-150,000			
150,000-200,000	50	16.2%	Madison (50)
Over - 200,000	39	12.6%	Milwaukee (39)
TOTAL	309	100.0%	

In what size community do graduates who are practicing in Wisconsin practice? (An analysis of graduates from 1965-1973)

What do these data indicate?

1. Thirteen percent *(13%)* of our graduates are practicing in Wisconsin communities of *less* than 5,000 population.
2. Thirty-four percent *(34%)* of our graduates are practicing in Wisconsin communities of *less* than 20,000 population.
3. Fifty-six percent *(56%)* of our graduates are practicing in Wisconsin communities of *less* than 50,000 population.
4. Sixteen percent *(16%)* of our graduates who are practicing in Wisconsin are practicing in Madison, a community in the 150,000-200,000 size category.
5. Twelve and six-tenths percent *(12.6%)* of our graduates who are practicing in Wisconsin are practicing in Milwaukee, a community in the over 200,000 population.

Future trends for choice of specialty practice and location for University of Wisconsin-Madison Medical School graduates

As indicated previously, practice location data can only be accurately analyzed for graduates through 1973, since the duration of most residency training programs precludes that most graduates will be settled in a practice location less than four to five years after graduation from medical school.

However, the trend in recent years has been for increasing numbers of medical school graduates to locate their practice in Wisconsin. All evidence indicates this trend will continue. The percentage of graduates taking a residency in Wisconsin has increased from a low of 5.3% in 1968 to a high of 37% in 1978. In another study Stone[1] has demonstrated that "the retention rate of graduates practicing in Wisconsin increases as the number of prior attachment events (born, medical school and internship/residency in the state) increases."

In respect to choice of practice specialty, the data from internship/residency training choices for the years 1974 through 1978 (graduates still not in practice) provide some clues to the probable practice specialty areas of our graduates. These data indicate that:

1. Two hundred and twenty eight (228), of the 686 graduates are in a primary care residency training program. (family practice, general medicine, pediatrics, and obstetrics/gynecology).
2. In addition, 172 or 25%, of the 686 graduates are in an internal medicine residency training program, many of whom will eventually be in a primary care medical practice.
3. Only 75, or 10.9%, of the 686 graduates are in a surgery residency training program.
4. The remaining 30% are in some type of "referral" specialty type residency training program.

Why graduates chose a practice location

Why medical school graduates chose a practice location is more difficult to answer, and many hypotheses have been suggested. In an attempt to shed more light on this question, several retrospective studies have been conducted at the University of Wisconsin-Madison Medical School asking graduates to rate 16 variables in terms of their importance in the choice of medical practice location. The data from 612 graduates for the period 1966-1975, from 213 internal medicine residents for the period 1935-1975, and from 135 current fourth year medical students ranked the variables as follows:

Variables* ranked very important	Cultural opportunities in community Size of community Proximity to a medical center Type of clinic or practice Quality of schools for children Spouses' preference Recreational opportunities in the community Opportunity happened to occur at the right time
Variables* ranked average importance	Climate Opportunity to teach Community need for physician
Variables* ranked as little importance	Financial considerations Opportunity to do research Family ties to community Residency location Tax advantages

*Variables in each cluster are not necessarily in rank order within that cluster.

These data, although retrospective reflections, except for the 135 fourth year students, on the importance of 16 variables in the decision regarding location of practice, point out the need to conduct on-going research to identify the factors that will attract physicians to practice in healthcare delivery shortage areas. A paradigm of studies, designed to analyze the decisions of specialty and practice location choice as they are being made, are now in progress at the University of Wisconsin-Madison.

Where do graduates of the University of Wisconsin-Madison Medical School practice medicine, and why?

In medical practice the quality of the medical in-

Table 4—The distribution of practice specialties of 1965-1973 graduates practicing in Wisconsin according to size of practice community

	Size of practice community						
Specialties	0-5,000	5,000-20,000	20,000-50,000	50,000-100,000	150-000-200,000	Over 200,000	Total
Aerospace medicine	1						1
Anesthesiology	2	3	1	2	1	1	10
Cardiovascular disease					1	1	2
Child psychiatry	1				1	1	3
Diagnostic radiology		3	4	3		1	11
Dermatology		2	2	2	2	1	9
Family practice	7	15	7	1	2	3	35
Gastroenterology			1				1
General practice	5	2	3	2	1		13
General preventive medicine					1		1
General surgery	3	3	5	1		3	15
Hematology					1		1
Infectious disease					1		1
Internal medicine	5	6	4	10	8	9	42
Nephrology						1	1
Neurology		2	2	1	2		7
Neurological surgery			1		1	1	3
Obstetrics & gynecology	1	2	1		4	3	11
Ophthalmology	2	2	4	2	2	2	14
Orthopedic surgery	4	4	12	3	2	2	27
Otorhinolaryngology				2	1	1	4
Clinical pharmacology		1					1
Pediatrics	2	2	9	6	3		22
Pathology		1	2	3	1		7
Plastic surgery					1		1
Psychiatry	2	2	3	3	7	4	21
Pulmonary disease				1			1
Radiology		4	3	2	3		12
Therapeutic radiology	1				1	1	3
Urological surgery		3	1	2	2	1	9
Unspecified	3	4	1		1	2	11
Other	1	3	3	1		1	9
TOTAL	40	64	69	47	50	39	309

tervention is a result of an accurate diagnosis of the medical problem. In fact, the quality of a solution to any problem is dependent upon an accurate analysis of what the problem is.

In respect to the distribution of physicians in the State of Wisconsin, the national data suggesting that a large percentage of a medical school's graduates leave that state to practice medicine, or that most of those who do stay go to the large cities to enter highly specialized practices, may well be true for some states, but it is not reflective of what is happening in Wisconsin.

- In recent years, the retention of graduates of the University of Wisconsin-Madison Medical School for practice in Wisconsin has averaged over 38%, and the trend is for the retention rate to increase.
- Close to 40% of the graduates practicing in Wisconsin from 1965-1973 are in a primary care practice.
- Thirty-four percent (34%) of our graduates who are practicing in Wisconsin are practicing in communities of less than 20,000 population and 56% are practicing in communities of less than 50,000 population.

Future emphases

It would appear that some of the current emphases given to the problem of physician maldistribution are having a desired effect on where our graduates are practicing and on the choice of a practice specialty. These emphases include:

- Externship and preceptorship training experiences provided for medical students.
- The Department of Family Medicine and Practice residency program.
- Smaller communities have enhanced their resources which will attract physicians. These include upgraded healthcare facilities and improved school systems and cultural offerings — factors associated with the opportunity for a good family life and the opportunity to practice good medicine.

Reference

[1]Internal Report for the University of Wisconsin-Madison Medical School by Howard L Stone, Director, Office of Educational Resources. ■

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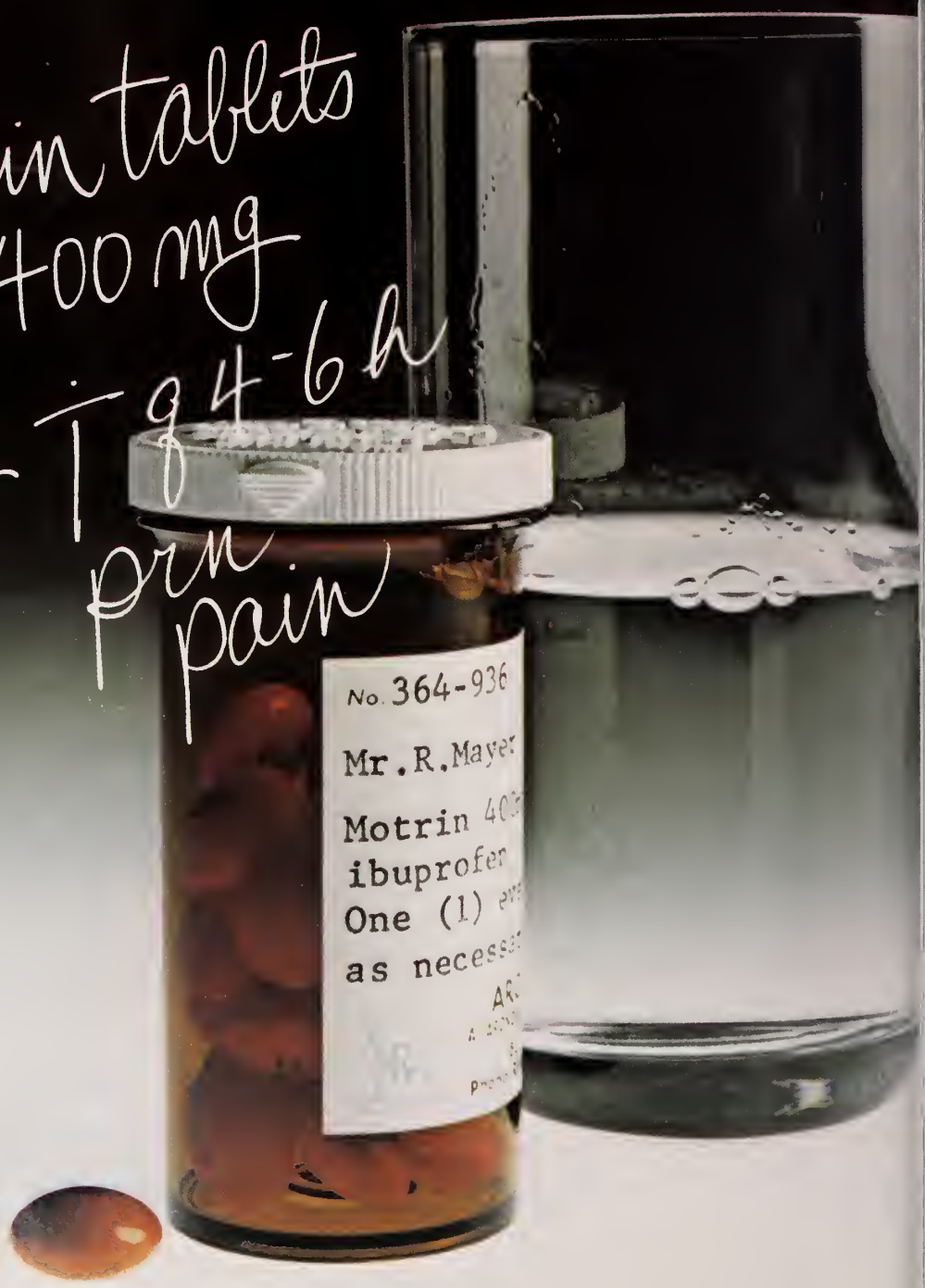

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*Incidence 3% to 9%.

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Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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Scientific Medicine

REFER TO: Optiz JC: Congenital hypothyroidism presenting as functional bowel obstruction in the premature infant. *Wisconsin Med J* 78:23-25 (Oct) 1979

KEY WORDS: Congenital hypothyroidism, intestinal obstruction, thyroid hormone, newborn disorders

Congenital hypothyroidism presenting as functional bowel obstruction in the premature infant

James C Opitz, MD, Marshfield, Wisconsin

● **The authors describe a premature newborn infant who, on the third day of life, developed symptoms and radiographic evidence of intestinal obstruction — the only clinical sign of congenital hypothyroidism. These findings were prolonged and dissipated only after thyroid hormone replacement had been started.**

CONGENITAL HYPOTHYROIDISM is often difficult to diagnose during the newborn period, and recently there has been a significant effort to promote widespread screening for congenital deficiency of thyroid hormone.[1-5] Signs and symptoms, however, do exist in the newborn period[6] that suggest the diagnosis of hypothyroidism. The purpose of this paper is to present a case report of congenital hypothyroidism in a premature infant in whom the signs and symptoms were related only to gastrointestinal dysfunction.

Case report. The patient, at birth on Nov 9, 1977, weighed 1700 gm. The mother was 41 years old, and this was her tenth pregnancy. Her expected date of confinement was Dec 2, 1977. Prior to this pregnancy she was hypertensive and on medications. During the third trimester, the hypertension became more severe. Medications included phenobarbital, methyldopa (Aldomet®), hydralazine (Apresoline®) and hydrochlorothiazide. Because of the increasing severity of the hypertension, it was elected to deliver her by cesarean section under general anesthesia. Apgar at one minute was 4 and at five minutes was 6. She did not require intubation but did receive oxygen and was moderately hypotonic.

The mother's first pregnancy (1957) resulted in a female infant who was diagnosed as a cretin at age six months. She is presently mentally retarded at age 20. The second pregnancy resulted in a male infant who died from a "choking spell" at the age of four days. Normal children who presently are living and well were produced by the third, fifth, sixth, seventh, and eighth pregnancies. The fourth child died at the age of four days from congenital heart disease. The male infant of the ninth pregnancy had repetitive episodes of abdominal distention and poor feeding during the first 10 days of life. He was sent home and readmitted at the age of two months with an acute illness that was thought to represent Reye's syndrome. Prior to his death a serum protein-bound iodine was performed which was reported to be low. An autopsy was not granted. There was no other evidence supporting familial hypothyroidism in this family.

From the Department of Pediatrics, Marshfield Clinic, Marshfield, Wisconsin. Publication support provided. Reprint requests to: James C Optiz, MD, Dept of Pediatrics, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449. Copyright 1979 by the State Medical Society of Wisconsin.

Examination. Weight 1700 gm, length 44.4 cm, head circumference 31.2 cm. This infant appeared small for gestational age. There was no evidence of macroglossia, umbilical hernia, abdominal distention, or other physical stigmata of hypothyroidism. Assessment of the integument and nervous system suggested a gestational age of 36 weeks. The remainder of the physical examination was normal.

Laboratory and x-ray studies. Complete blood count and urinalysis were normal. Sodium - 143 mEq per liter; potassium - 5.0 mEq per liter; blood glucose - 71 mg per dl; calcium - 8.8 mg per dl; total serum protein - 6.0 gm per dl; serum pH - 7.35; blood urea nitrogen - 6.0 mg per dl; magnesium - 1.6 mg per dl. On Nov 28, 1977 the following thyroid function studies were obtained: serum thyroxin - less than 1.0 mcg per dl; free T4 - 0.23 ng per dl; TSH - greater than 50 microunits per ml. On Dec 1, 1977 several studies were repeated. T4 - less than 1.0 mcg per dl; total T3 assay - 28 ng per dl; T3 uptake - 33%; thyroid binding globulin - 27 mg per ml; TSH - greater than 50 microunits per ml; free T4 - 0.20 ng per dl.

Course. This infant was admitted to the Neonatal Intensive Care Nursery for observation and management. There was no evidence of cardiopulmonary difficulty, and formula feedings were started at four hours of age. She developed mild jaundice, with a peak serum bilirubin of 10.9 mg per dl, on Nov 14, 1977 (indirect fraction was 9.5 mg per dl). On Nov 12, 1977 she had moderate abdominal distention with bilious gastric aspirates, and occasional small, bile-stained emesis. She had been passing meconium and transitional stools. X-ray film of the abdomen revealed an ileus pattern with bowel wall thickening without evidence of pneumatosis intestinales. Oral feedings were discontinued and she was placed on a modified peripheral hyperalimentation program, along with administration of antibiotics, because of suspected necrotizing enterocolitis. She rapidly improved; however, one could easily palpate persistent loops of thickened bowel wall. Feedings were resumed on Nov 22, 1977 using Isomil® .

By Nov 26, 1977, at age 17 days, she again became distended with an ileus pattern and because of bile emesis, oral feedings were again discontinued. Upper gastrointestinal with small bowel series and barium enema at this time were normal. At times she seemed mildly hypotonic, and the nurses thought she slept more than usual. The results of repeat thyroid function studies confirmed the original thyroid studies.

On Dec 1, 1977, at age 22 days, with weight of 1873 gm, she was started on intravenous L-Thyroxin. The initial dose that was administered was 20.0 mcg. At this time her nutrition was being maintained with central hyperalimentation using intralipid and freeamine. After seven days she was tolerating oral L-Thyroxin in a dosage of 15 mcg per day and also at this point was beginning to tolerate oral feedings. There was no further intolerance of feedings and she was discharged on Dec 27, 1977, with a weight of 2600 gm, receiving L-Thyroxin 15 mcg per day, and the total serum thyroxin level was normal. At age seven months neurologic and physical parameters were normal.

Discussion. It is felt that this clinical presentation for congenital hypothyroidism is unique. The manifestations were essentially limited to the gastrointestinal tract, with the exception of intermittent mild hypotonia. Throughout the first three weeks of life there were no cutaneous findings of hypothyroidism and stool passage was normal.

There is very little doubt regarding the diagnosis of hypothyroidism in this patient. The total thyroxin and free T4 value are very low for this gestational age infant. The fetal serum thyroxin level gradually rises from the 12th gestational week to the full termination of pregnancy. Values at 26 weeks gestation approximate 10 mcg per dl. This infant on two separate occasions had total thyroxin values of less than 1 mcg per dl, strongly supporting the diagnosis of hypothyroidism.

Feeding problems are certainly common in congenital hypothyroidism but are usually associated with multiple other findings.[6] Forty percent of the infants reviewed by these authors had feeding problems. In the same paper unpublished data from Pittsburgh reporting 31 infants with hypothyroid symptoms (before the age of three months) revealed an incidence of feeding problems - 39%, mottling - 58%, decreased activity - 39%, enlarged tongue - 45%, hoarse cry - 39%, constipation - 52%; and umbilical hernia - 58%. Intestinal obstruction was not identified in this group of patients.

Hypothyroidism in the above case report presenting with symptoms of frank intestinal obstruction, indeed, is an unusual initial symptom complex in congenital hypothyroidism. Feeding problems and constipation[7] were commonly seen in a group of 39 cretins during their first month of life, along with other findings; however, bowel obstruction was not seen.

Newborn infants have been reported[8] who have died during the first weeks of life from hypothyroidism despite replacement therapy. It is conceivable that the intestinal manifestations of the disease interfere with hormonal absorption; and thus during the neonatal period when symptoms of intestinal obstruction are present, it may be appropriate to give thyroxin intravenously.

Myxedema in adults has been referred to as a rare cause of intestinal obstruction. Hohl and Nixon[9] described three instances of paralytic ileus

in 89 adults with hypothyroidism from 1953 to 1963. Failure to recognize myxedema as a cause of paralytic ileus could be potentially disastrous should laparotomy be performed. Bastenie[10,11] reported necropsy findings of significant dilatation and/or lengthening of the colon, atrophy of the intestinal mucosa, and mucinous and fatty infiltration of the intestinal wall in 17 fatal cases of myxedema. The wall of the colon was thickened and whitish and felt like soft leather. There was loss of elasticity. Microscopic examination revealed myxedematous infiltrates of the stroma, atrophy of the mucosa and diffuse infiltration of the submucosa by lymphocytes and plasma cells. Some of the myxedematous infiltrate was interposed between the muscular fibers and the ganglion cells of Auerbach and Meissner. This allowed Bastenie to construe that the loss of elasticity and tone and subsequent paresis were related to faulty transmission of neural impulses at the myoneural junction. In a subsequent study utilizing manometric investigation, Duret and Bastenie[12] demonstrated reduced intraluminal pressure in the colon during the myxedematous state. Under the influence of a muscarinic drug (carbamyl-β-methylcholine), many of the hypothyroid patients, however, did demonstrate colonic power of contraction, supporting the concept that this process in some instances is reversible.

Knowledge that intestinal obstruction may be an early sign of hypothyroidism in the newborn may facilitate early diagnosis. The pathogenesis of such intestinal obstruction is a matter of conjecture, but could be related to a combination of inadequate blood flow and loss of oxidative capability within the mitochondria. Certainly, the above microscopic findings with the associated myxedematous infiltrate in the intestinal wall must have a close relationship to the development of atony. However, the precise cellular pathogenesis is unknown. It is well known that thyroid hormones influence the metabolism of oxygen, water and minerals together with carbohydrates, lipids and proteins, to yield energy. They stimulate the functions of most organs and gastrointestinal motility is reduced in the hypothyroid state as noted previously.

Summary. This premature infant with hypothyroidism presented during the first week of life with clinical signs of intestinal obstruction. It is important to recognize that this may be an early manifestation of this disorder.

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Abstracts

Osteomyelitis of the mandibular condyle secondary to dental extractions

LEONARD H WURMAN, MD; JOHN V FLANNERY JR, MD; J GARRY SACK, MD; Wausau: *Otol Head Neck Surg* 87: 190-198 (Mar-Apr) 1979

Although osteomyelitis of the mandibular condyle secondary to dental extraction is scarcely mentioned in the medical and dental literature, we have seen three cases within a two-year period. The first two patients were examined for an eroded condyle three months and 18 months following the extractions. The third patient, who was treated one month after extraction for acute osteomyelitis of the condyle, has done well. All three patients required operations and administration of long-term antibiotics. ■

Aerosol beclomethasone treatment of chronic severe asthma: a one-year experience

STEPHEN A IMBEAU, MD and MARIO GELLER, MD (Univ of Wisconsin Center for Health Sciences, Madison) *JAMA* 240:1260-1262 (Sept) 1978

After one year's use of beclomethasone dipropionate aerosol, 43 of 61 asthmatic patients who were originally dependent on oral corticosteroids were able to reduce and 38 to completely eliminate use of oral corticosteroids. Most patients maintained or improved their pulmonary functions. Exacerbation of rhinitis during oral corticosteroid withdrawal and emergency of nasal polyps were problems for 25 patients. Exacerbation of asthma with upper respiratory infections was an important event: 21 patients required supplemental oral corticosteroids to control asthma. Oral candidiasis occurred in only three patients. ■

REFER TO: Chudwin D, Copps S, and Byron A: Galactosemia and obstructive hydrocephalus. *Wisconsin Med J* 78:26-27 (Oct) 1979

KEY WORDS: Galactosemia, pseudotumor cerebri, aqueductal stenosis, hydrocephalus

Galactosemia and obstructive hydrocephalus

David Chudwin, MD; Stephen Copps, MD; and **Byron Annis, MD,** La Crosse, Wisconsin

GALACTOSEMIA MAY ON occasion present initially as pseudotumor cerebri, with full fontanels and increased intracranial pressure.[1,2] This has been attributed to diffuse cerebral edema, possibly due to the osmotic effect of galactose derivatives in the brain.[1,3] We describe here an infant with galactosemia whose presenting problems included full fontanels, increased head circumference, and failure to thrive. Diagnostic studies revealed obstructive hydrocephalus, probably due to aqueductal stenosis. While the combination of aqueductal stenosis and galactosemia may be coincidental in this patient, the case illustrates that in infants with galactosemia full fontanels and other signs of increased pressure may be due to etiologies other than pseudotumor cerebri.

Case Report. The patient was the product of an uncomplicated, full-term pregnancy to a healthy 19-year-old married primigravida. The infant was delivered vaginally, with an Apgar score of 9 at 1 and 5 minutes. Birth weight was 3.15 kg and length 49.5 cm; no head circumference was recorded. There is no record of postnatal jaundice. She was fed formula, but after discharge from the hospital she reportedly took only 30-60 cc per feeding with a total intake of less than 240 cc per day. This poor feeding was attributed to "sleepiness." There was no history of vomiting.

At four weeks of age the patient was first admitted for failure to thrive. On admission her weight was 2.60 kg (less than 3rd percentile for age), her length 52.5 cm (3rd percentile), and her head circumference 39.75 cm (greater than 98th percentile). The anterior fontanel was 4x4 cm and full; the posterior fontanel was 3x3 cm. The coronal, lambdoidal, and sagittal sutures were spread. The pupils were equal and reactive to light with a red reflex present and the lenses clear. Transillumination of the skull was abnormally increased bilaterally. Examination of the chest and heart was unremarkable. The abdomen was soft with the liver edge palpable 2.5 cm below the right costal margin. A neurologic examination showed an alert but irritable emaciated infant. The cranial nerves were intact. She had normal muscle tone and strength. Moro, grasp, step and tonic neck reflexes were present. Mild scissoring was noted on standing. Head control was poor. Deep tendon reflexes were 3+ at the knees with upgoing plantar responses.

Initial laboratory studies included a hemoglobin level of 10.8 gm per dl, serum sodium 134 mEq per liter, serum potassium 4.7 mEq per liter, and blood urea nitrogen 15 mg per dl. Computerized axial tomography revealed hydrocephalus with enlarged ventricles bilaterally. Air ventriculography revealed large ventricles and reduced cerebral mantle ranging from 0.5 to 1.7 cm. The area of the aqueduct was not defined and no gas passed beyond the third ventricle in spite of appropriate positioning of the patient's head. Indigo carmine introduced into the ventricle was not recovered from spinal fluid obtained by lumbar puncture shortly thereafter. These observations were felt to support the diagnosis of hydocephalus secondary to aqueductal stenosis. Four days after admission, at one month of age, a ventriculoperitoneal shunt was placed.

Postoperatively the patient failed to gain weight, even when her intake was advanced to 140 kcal per kg per day of formula. Approximately two weeks after surgery, the infant was noted to have an enlarged liver extending 5 cm below the right costal margin. Serum glutamic pyruvic transaminase (SGPT) was 38 units (normal to 35), serum protein 5.1 gm per dl and serum albumin 2.58 gm per dl. Liver biopsy revealed fatty metamorphosis with early cirrhosis, felt to be consistent with galactosemia. Urine was positive for reducing substances, but negative by glucose oxidase test strips. Galactose was identified in the

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urine. An ophthalmologic examination at this time demonstrated the development of faint bilateral lamellar cataracts. Enzyme assay of erythrocyte galactose-1-uridyl transferase revealed an activity of 1.9 units per gram hemoglobin in the patient, 9.6 in her father, and 8.6 in her mother (control 22.9 units per gram hemoglobin).

At seven weeks of age the infant was started on Nutramigen®, a casein hydrolysate formula with virtually no galactose. The patient, who weighed 2.83 kg at the time, gained 790 gm over the next two weeks. When discharged, she was thriving and her enlarged liver had begun to recede.

Discussion. Huttenlocher *et al* described three infants with galactosemia who presented initially with bulging fontanels, jaundice and hepatomegaly in the first month of life.[1] In each case there were signs of increased intracranial pressure attributed to diffuse cerebral edema, but normal head circumference and negative transillumination. More recently, Vogel *et al* described an infant who was admitted at six months of age with a bulging fontanel, vomiting, and failure to thrive; the diagnosis was galactosemia.[2] They suggest that galactosemia should be considered in the differential diagnosis of infants with increased intracranial pressure, hepatomegaly, and failure to thrive.

In our case a female infant was admitted at four weeks of age for failure to thrive. At that time her liver size was not significantly enlarged, and attention was focused on hydrocephalus suggested by increased head circumference, full fontanels, and widened sutures. The hydrocephalus was confirmed by computerized tomography and a ventriculogram, and a Black-Fan study suggested aqueductal stenosis. Only two weeks later, after a shunting procedure, did the hepatomegaly suggest the possibility of galactosemia, which was subsequently demonstrated by liver biopsy, galactosuria, and erythrocyte enzyme levels.

The combination of galactosemia and aqueductal stenosis has not been described in a large series by Donnell *et al*,[4] Nadler *et al*,[5] or Komrower and Lee.[6] The occurrence of both in a single patient may very well be fortuitous, since the diffuse cerebral edema which appears to be the chief brain pathologic finding on autopsy[3] would not likely produce obstructive hydrocephalus due to aqueductal stenosis. This case does point out that etiologies other than pseudotumor cerebri may cause bulging fontanels and increased intracranial pressure in patients with galactosemia.

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Abstracts

Microscopically controlled surgery for extramammary Paget's disease

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Arch Dermatol 115:706-708 (June) 1979

Extramammary Paget's disease of the vulvar, perineal, and anal region of four women and of the scrotum and groin of a man were removed under complete microscopic control in the chemosurgery clinic. All have remained free of recurrence after periods of from four months to nine years.

The microscopic control is needed because the neoplasm typically extends for several centimeters beyond the clinically visible borders. Not only does the microscopic control ensure eradication of the cancer but also it permits maximal conservation of normal tissues because there is no need to remove a wide extra margin of uninvolved tissue. Although the large, clear Paget's cells are the most striking histologic feature, the operator should be familiar with the smaller, less mature Paget's cells that predominate as the periphery of the neoplasm is approached. ■

Trifluridine in resistant human herpetic keratitis

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Arch Ophthalmol 96:1839-1841 (Oct) 1978

Patients with active dendritic herpetic keratitis that was unresponsive to topical idoxuridine or vidarabine therapy were treated topically with a 1% solution of trifluridine. The dendritic ulcers healed in an average time of 6.1 days. All patients tolerated the drug well except for one patient in whom a reversible crystalline epithelial keratitis developed. ■

REFER TO: Boxer RJ, Skinner DG, Goodwin WE: The ileal ureter in recurrent nephrolithiasis. *Wisconsin Med J* 78:28-31 (Oct) 1979

KEY WORDS: Nephrolithiasis, ureteral disease, intestinal replacement, renal function, ileal ureter

The ileal ureter in recurrent nephrolithiasis

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● **The total replacement of the ureter by small intestine has been performed on 49 patients with recurrent nephrolithiasis at UCLA Medical Center during the period 1959-1977. Fourteen of these patients had a concurrent ureteral stricture, a particularly compelling reason for employing the ileal ureter. The followup was at least one year; 17 were followed for five years, nine were followed for 10 years, and two were followed for more than 15 years. The operation was defined as a success if all the following criteria were met: (1) renal function on the affected side was preserved; (2) recurrent calculi were not troublesome; (3) subsequent diversion was not necessary; and (4) serum electrolytes were not abnormal. Forty-three (88%) of the patients were successfully treated by this operation. The serum creatinine was greater than 2 mg percent in the group of patients that had an unsuccessful operation. Thus, an elevated serum creatinine is a contraindication to the procedure. In addition we found: (1) postoperative reflux was not disadvantageous; (2) the bladder neck did not require surgical revision by Y-V plasty or transurethral resection if normal drainage was demonstrated; (3) nephrostomy tube was absolutely essential; (4) isoperistaltic segments of ileum must be used; and (5) the pyeloinfundibulo-calyco-uretero-ileal anastomosis was the most common procedure, and seven patients required a lower pole partial nephrectomy. We believe this operation is an excellent method of treating specially selected patients with recurrent nephrolithiasis, especially if concurrent ureteral stricture is present.**

THE URETER HAS BEEN partially or completely replaced by the small intestine for 70 years.[1] The indications have been stricture, fistula, injury, ureteral carcinoma in a solitary ureter, tuberculosis, retroperitoneal fibrosis, and congenital obstruction. In 1959 Goodwin and associates [2-10] described a technique and expanded the indications to include a treatment for multiple recurrent calculi.

At UCLA and affiliated hospitals between 1954 and 1978, 93 patients had an ileal ureter operation performed 95 times. In the period 1959-1977, 49 patients have had the ileal ureter for recurrent nephrolithiasis. We believe this operation is an excellent method of treating recurrent nephrocalcinosis, especially if ureteral stricture is concomitantly present.

Materials and Methods. The medical records of 93 patients who had intestinal replacement of all or part of the ureter in the years 1954-1977 were reviewed. Telephone or written communication was established with most patients lost to followup prior to the study. A final judgment of the results on 88 (95%) of the patients was made by one of the authors of this paper (RJB). Followup examination included the clinical evaluation, serum creatinine and electrolytes, intravenous urogram, and in the majority of cases a cystogram. Forty-nine patients had the ileal ureter performed for recurrent nephrolithiasis. Eleven patients were followed for three to five years; 21 were followed for five years; 12 were followed for 10 years; and two were followed for more than 15 years.

The result was deemed successful if renal function on the affected side was preserved, recurrent calculi were no longer troublesome, subsequent urinary diversion was not necessary, serum electrolytes were not abnormal, pyelographic appearance was unchanged or improved, and the patient was without symptoms.

All available pyelograms and cystograms were reviewed by a radiologist.

Results. There were 20 males (41%) and 29 females (59%) with recurrent nephrolithiasis requiring the ileal ureter. The average age of the patient at the time of the operation was 45 years, with a range of 16-67. Each patient had an average of three operations for calculus disease prior to

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Table 1—Comparative renal function. Information available on 75 patients with operative success and failure

Preoperative Serum Creatinine (MG%)	Number Patients	Postoperative Serum Creatinine (MG%) 0-0.9	1-1.9	2-2.2	3	Success (%)	Failure (%)
0-0.9	19	13	6	0	0	17 (89.5)	2 (10.5)
1-1.9	45	7	28	6	4	39 (86.7)	6 (13.3)
2-2.9	9	0	1	5	3	6 (66.7)	3 (33.3)
3	2	0	0	0	2	0	2 (100)

[From: Boxer RJ, Fritzshe P, Skinner DG, Kaufman JJ, Belt E, Smith RB, and Goodwin WE: Replacement of the ureter by small intestine; clinical application and results of the ileal ureter in 89 patients, *J Urol* 121:728, 1979 and *Trans Amer Assoc Genitourinary Surgeons* 70:99, 1979.]

having the ileal ureter. One patient with hyperparathyroidism had 10 previous operations.

One patient died of hemorrhagic pancreatitis in the immediate postoperative period, an operative mortality of 1.1 percent in the entire group of 93 patients.

The etiology of the stone disease was determined in only 11 patients, although all patients had serum and urine phosphorus, calcium and uric acid levels. The stones that were previously passed were analyzed and all of the patients failed nonoperative medical management. Five of the patients had cystinuria, four had hyperparathyroidism (all had neck explorations, yet continued to have nephrocalcinosis), and two patients had renal tubular acidosis. Fourteen patients had strictures of the ureter in addition to stone disease. Eighteen patients had a solitary kidney and one patient had a horseshoe kidney.

Renal function as determined by serum creatinine was recorded in 38 patients pre- and postoperatively. It was unchanged or improved in 33 (87%) of the patients. In the entire group of 93 patients, 75 had renal function recorded. In this group serum creatinine was less than 2 mg percent preoperatively in 64 patients, and 88 percent of

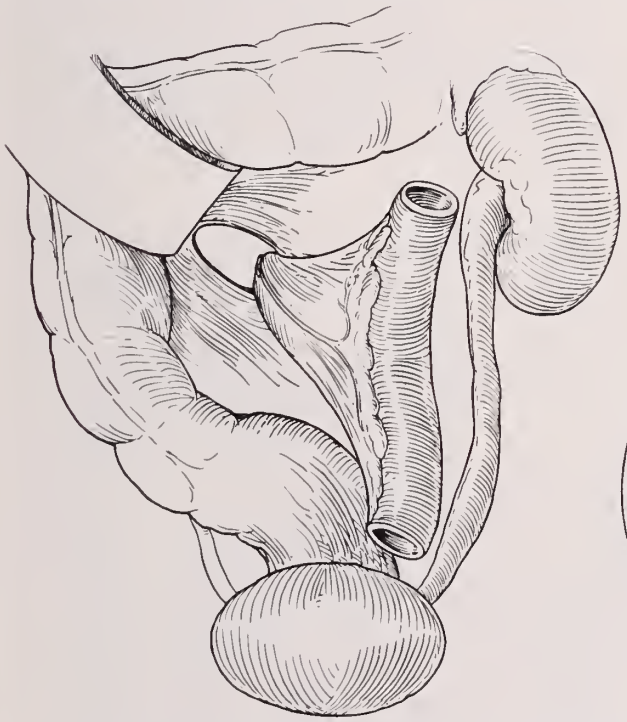

FIGURE 1—Left ileal segment drawn through window in mesocolon. (Reprinted from Boxer[13] with great appreciation to Donald Skinner, MD who designed the figure.)

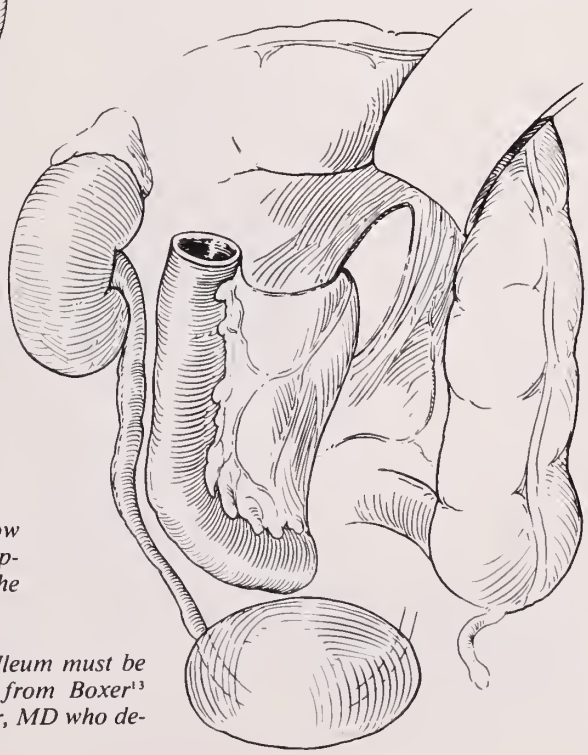

FIGURE 2—Right ileal ureter in place. Ileum must be rotated to be isoperistaltic. (Reprinted from Boxer[13] with great appreciation to Donald Skinner, MD who designed the figure.)

these patients had a successful outcome. However, of the 11 patients who had serum creatinine 2 mg percent or greater, five (46%) developed hyperchloremic acidosis and subsequently required cutaneous ileal diversion (Table 1).

Recurrent or residual calculi were seen in 20 of 38 patients evaluated by postoperative intravenous urograms. Only one of those 20 patients was considered a therapeutic failure. The other 19 patients had no loss of renal function and were able to pass the stones without pain or illness.

Vesicoileac reflux was evaluated by cystogram in 30 patients. The serum creatinine and pyelographic appearance was unchanged or improved in 21 (91%) of the 23 patients with postoperative reflux. No reflux was seen in seven patients, and all had a successful long-term result.

The bladder must be capable of completely emptying after the interposition of intestine in the urinary tract. Bladder neck revisions (Y-V plasty, open bladder or transurethral bladder neck resections) were performed on 16 patients thought to have impending outflow obstruction; 15 (94%) had a successful outcome. However, 32 patients had no bladder neck revision and 28 patients (88%) had complete bladder emptying and successful outcomes.

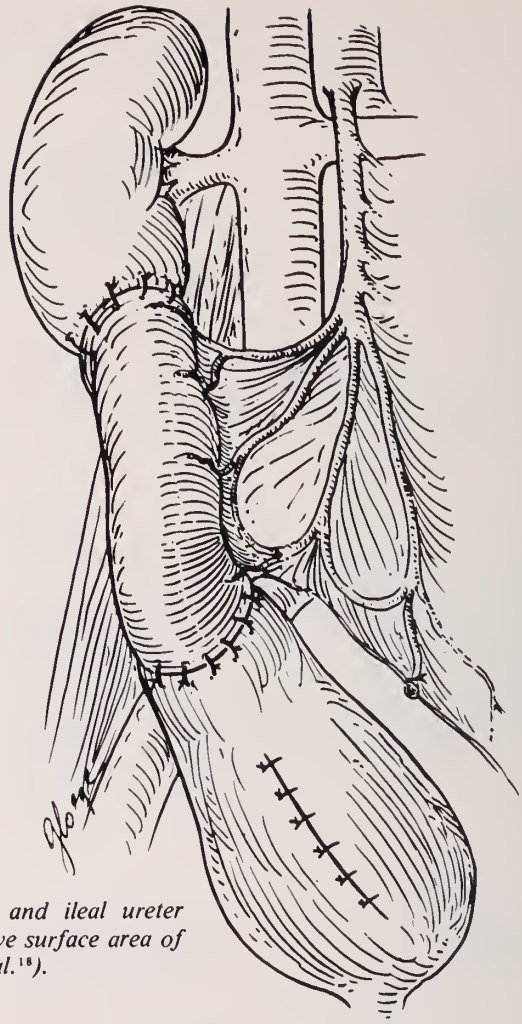

FIGURE 3—The vesicopsoas hitch and ileal ureter completed. This reduces the absorptive surface area of the ileum. (Reprinted from Ehrlich et al.[18]).

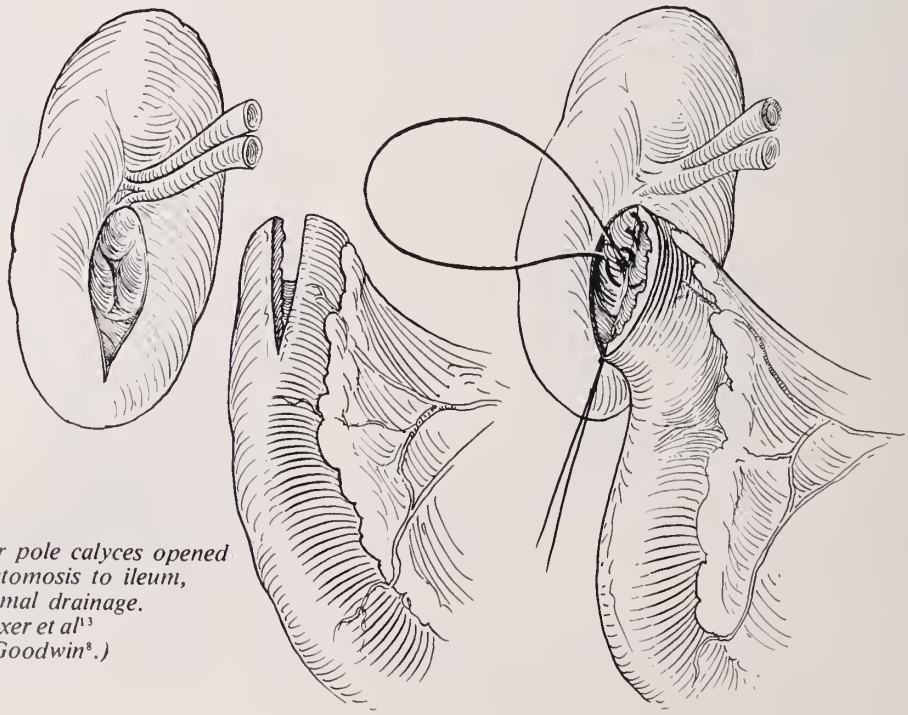

FIGURE 4—Lower pole calyces opened to allow wide anastomosis to ileum, thus assuring maximal drainage. (Reprinted from Boxer et al[13] and redrawn from Goodwin[8].)

Discussion. Partial or complete replacement of the ureter by intestine is an important therapeutic option for patients with recurrent calculi, ureteral injury or disease, ureteral carcinoma, congenital ureteral dysfunction or for patients suitable for undiversion.[11-14] In this series of 49 patients with recurrent nephrolithiasis, 43 (88%) were successfully treated. The interposition of intestine did not adversely affect the serum electrolytes or creatinine in patients who had a preoperative serum creatinine less than 2 mg percent. *An elevated serum creatinine is a contraindication to the procedure.*

The combination of a ureteral stricture and nephrolithiasis, present in 14 patients, is a particularly compelling reason for the ileal ureter.

The technical aspects of the procedure have been described previously, but several points merit emphasis.[6,8,12,14] The procedure can be extremely difficult and time-consuming. The intestinal segment should always be used in an isoperistaltic manner (Fig 1,2). Although the ileum is desirable because of the mobility of the mesentery, other segments of the intestine are equally suited for the procedure. Richie and Skinner[15] demonstrated that the emptying ability of the colon was equivalent to that of the ileum when used for cutaneous urinary conduits. The absorption of electrolytes in the ileum is the same in equivalent segments of the colon.[16] To reduce the absorptive surface area, we have recently used the vesicopsoas hitch[12,17,18] (Fig 3). Wide proximal anastomosis between the ileum and the ureter, pelvis, lower pole calyx, and infundibulum is important (Fig 4). In seven patients a lower pole partial nephrectomy was performed to increase the size of the anastomosis and remove stones. However, the necessity for maintaining parenchyma cannot be overemphasized.

A nephrostomy tube is absolutely necessary to protect the anastomosis. Stents are generally not used. When possible, it is desirable to retroperitonealize the intestinal segment. Bladder neck enlargement may not be necessary if the patient can void to completion. However, if there is any question of outlet obstruction, the bladder neck demands revision.

Addendum. Since the writing of this paper, one patient developed the complication of developing a stenosis at the ileal pelvic juncture and one patient developed a stenosis at the ileovesical juncture. Both were corrected by incising along the antimesenteric border of the ileum and reanastomosing a larger portion of the ileum to the renal pelvis and bladder, respectively.

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Abstracts

Staphylococcal scalded skin syndrome in an adult with Hodgkin's disease

HAL B RIDGWAY, MD; NICHOLAS J LOWE, MD, University of Wisconsin Hospitals, Madison, Wis: *Arch Dermatol* 115:589-590, 1979

Staphyloccal scalded skin syndrome is an acute bullous skin disease in which large areas of epidermis are exfoliated, giving the clinical appearance of scalded skin. It is caused by an epidermolytic toxin produced by particular strain of *staphylococcus aureus.* The disease is usually seen in children and has a favorable prognosis with early diagnosis and appropriate antibiotic therapy. We report the occurrence of this syndrome in an adult with Hodgkin's disease on multiple drug chemotherapy. Despite appropriate treatment the patient died. Our review of the literature indicates a much worse prognosis (mortality rate of 54%) for adults having this syndrome. ■

REFER TO: Sty JR, Babbitt DP, Boedecker RA: Bone scintigraphy: Methotrexate associated bone necrosis. *Wisconsin Med J* 78:32-33 (Oct) 1979

KEY WORDS: Bone scintigraphy, ischemic bone necrosis, methotrexate, leukemia

Bone scintigraphy: Methotrexate associated bone necrosis

John R Sty, MD; Donald P Babbitt, MD; and **Robert A Boedecker, MD,** Milwaukee, Wisconsin

● **A case of ischemic bone necrosis in a child with acute lymphocytic leukemia treated with methotrexate is discussed.**

SEVERAL STUDIES HAVE demonstrated the occurrence of bone necrosis in acute leukemia.[1,2,3] Bone necrosis is common in acute lymphocytic leukemia, and quite uncommon in acute myelocytic leukemia. In addition, chemotherapeutic agents have been incriminated as an etiologic factor.[1,4]

Bone pain is frequent in children with leukemia;[3] however, it is severe in only a minority of patients, and in this group the pain is often associated with ischemic bone necrosis.

Frequently, extensive and widespread bone necrosis may occur with failure to produce specific radiographic change.[2,5] However, bone scintigraphy is a sensitive method to demonstrate ischemic bone necrosis regardless of the etiology.[6,7,8]

Reprint requests to: John R Sty, MD, Department of Radiology, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201. Copyright 1979 by the State Medical Society of Wisconsin.

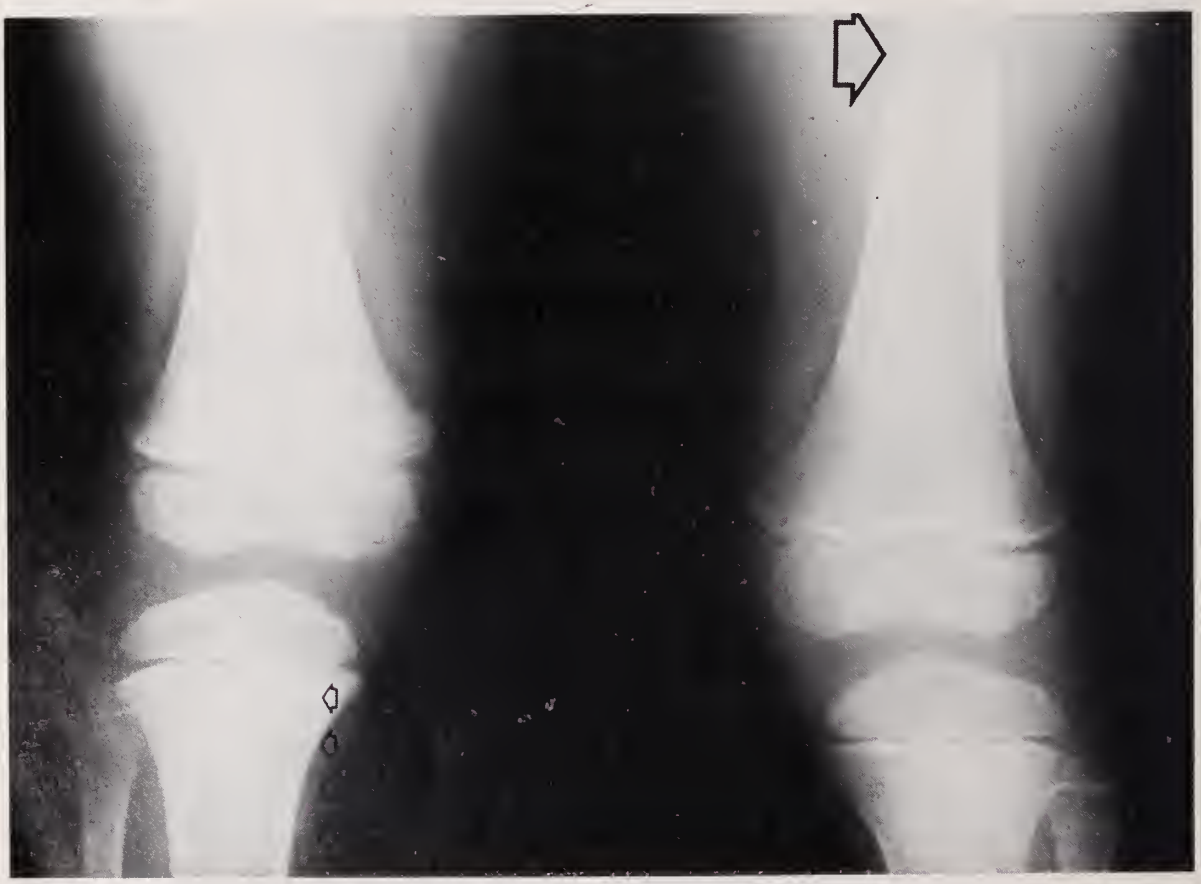

FIGURE 1—Roentgenogram. Note the osteoporosis, growth arrest lines (small open arrows), and periostitis (large open arrow).

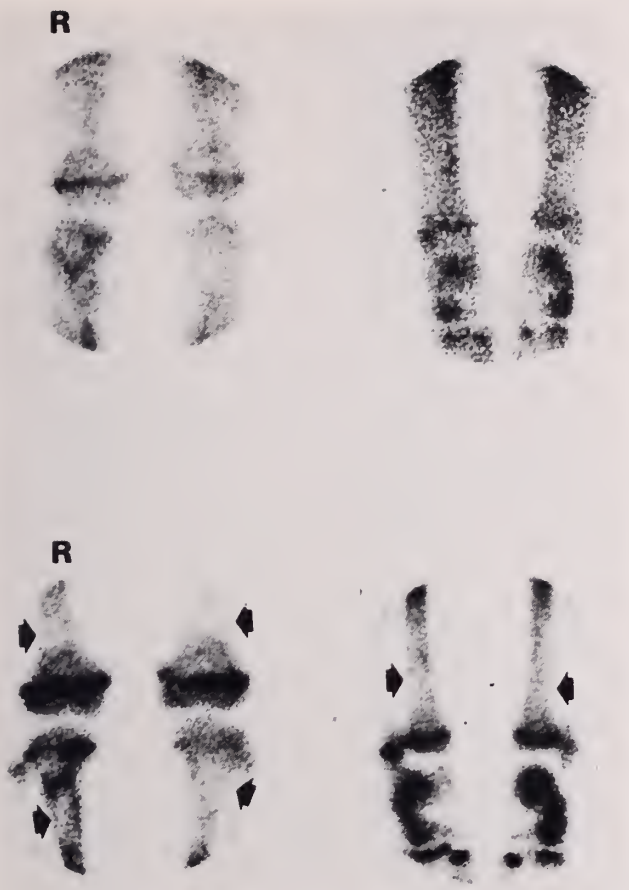

FIGURE 2—Bone scintigram; blood pool delayed images. Solid arrows mark regions of ischemic necrosis.

Case report. Our patient was a five-year-old white male with the diagnosis of acute lymphocytic leukemia of two years duration. While being treated with methotrexate for relapse, he developed severe right knee pain. X-ray studies and bone scintigraphy (8.3 mCi/m² of 99mTc-methylene-diphosphonate) were obtained. The x-ray films demonstrated osteoporosis, growth arrest lines, and diaphyseal periosteal reaction (Fig 1). Bone scintigraphy consisted of blood pool and delayed images. The blood pool images demonstrated increased activity in the peripheral region of an ischemic area. Delayed images demonstrated multiple photon deficient areas secondary to ischemic necrosis (Fig 2). Biopsy of the right proximal tibia demonstrated necrotic, packed cells in the marrow along with leukemic blast cells. The child died shortly thereafter.

Table 1—Epiphyseal-metaphyseal ischemia

COMMON
1. Idiopathic (*eg*, Legg-Perthes disease)
2. Sickle cell or other primary anemia
3. Osteochonritis dissecans
4. Steroid therapy
5. Trauma

UNCOMMON
1. Gaucher's disease
2. Infection, osteomyelitis
3. Radiation therapy
4. Hemophilia
5. Histiocytosis X
6. Methotrexate therapy
7. Leukemia

Discussion. The following discussion describes the scintigraphic and pathologic findings in bone ischemia and necrosis following treatment with methotrexate in a child with acute lymphocytic leukemia. Pathologically, it is difficult to determine whether ischemic necrosis is a direct effect of the leukemia or methotrexate.

When ischemic necrosis occurs in leukemic patients, both bone marrow and spicules are involved in multiple regions. Histologically, the earliest marrow changes consist of pyknosis and karyorrhexis of the densely packed leukemic cells. Bone spicules contain viable osteocytes, but many of the small vessels are obstructed by compression or filled with eosinophilic debris. Within two weeks only necrotic packed cells are found in the marrow cavity, and a zone of granulation is noted around the ischemic bone necrosis. Our patient had right knee pain for approximately ten days prior to imaging. The increased activity in the blood pool images represents the region of granulation around the necrosis. Delayed photon deficient areas represent regions of necrosis. Histologically, these regions will demonstrate a lack or a paucity of osteocytes in the bone spicules and amorphous, coagulated packed leukemic cells in the marrow cavity.

The course of ischemic bone necrosis is variable. Frequently, metaplastic bone spicules form new bone in the reactive zone followed later by osteoblastic new bone formation.

Bone scintigraphy is sensitive but not specific for leukemic ischemic necrosis. Table 1 lists etiologies of epiphyseal-metaphyseal ischemic necrosis in children.

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REFER TO: Mazza JJ: The granulomatous reaction — its role in the host response. *Wisconsin Med J* 78:34-37 (Oct) 1979

KEY WORDS: Granulomatous response, immune granulomas

The granulomatous reaction — its role in the host response

Joseph J Mazza, MD, Marshfield, Wisconsin

• A brief review of the histology and function of a granuloma is presented along with the types of antigens that might elicit a granulomatous response. Speculation on the role of the granulomatous reaction in the host immune response is made and the possibility of this type of reaction being an indication of compromised immune status of the host is discussed in association with certain diseases.

GRANULOMAS ARE A peculiar, specific type of inflammatory and immune response by the host to a specific inciting antigen. Not much is actually known about the granulomatous reaction and the nature of this type of response, but we do associate granulomatous reactions with certain types of antigens and assume that this type of reaction is a primary response by the host to that antigen. Because so little is known about the nature of the granuloma and the granulomatous response to certain antigens, a number of questions come to mind when considering this type of response and the role of this type of reaction in the overall immune system of the host. (1) Why do only certain diseases or antigens elicit a granulomatous type of response? (2) How does the granulomatous reaction fit into the overall scheme of immunity or the immune response of the host? (3) Why is the granulomatous reaction elicited in some individuals and not in others when challenged by the same antigen?

Granulomas are a specific type of inflammatory response consisting of a follicle-like aggregation of phagocytic mononuclear cells elicited by an antigen for the purpose of controlling or containing that antigen (Fig 1, 2). Macrophages from the tissue and/or the blood move to the area of the inciting antigen and arrange themselves around the antigenic material so as to localize or contain the antigen in a cluster of viable phagocytic cells. These macrophages mature and form what are known as "epithelioid cells." The factors that induce the transformation of macrophages into epithelioid cells remain uncertain. These epithelioid cells exist in the immediate areas surrounding the antigen and sometimes coalesce to form what are called "giant cells" (Fig 3, 4). It is the function of these altered macrophages or epithelioid cells to alter, degrade or destroy the antigenic material within the granuloma. These macrophages in becoming epithelioid cells undergo certain changes that alter their function and ultrastructural characteristics. A well-developed rough endoplasmic reticulum and Golgi apparatus can be seen on electron microscopy. These epithelioid cells seem to lose their ability to phagocytize and become more committed to a secretory rather than a phagocytic role. It has been shown that granulomas will persist for as long as the antigen remains antigenic provided that the immune system of the host is not altered.

We know that granulomas can be dissolved or broken down with certain drugs such as corticosteroids and by immunosuppressive agents such as cyclophosphamide. In some instances, the breakdown of the granulomas which are suspected of localizing and containing the antigenic material may prove to be deleterious to the host resulting in reactivation and proliferation of a systemic disease process as one might see with the breakdown of the granulomas in tuberculosis. In other instances, however, dissolution of the granulomas might be beneficial and correspond to abatement of the systemic signs and symptoms as well as

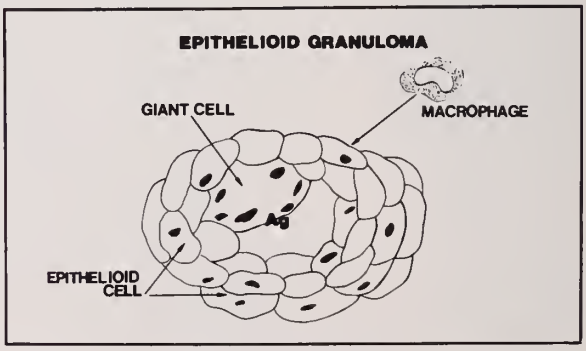


FIGURE 1—Schematic representation of an epithelioid granuloma. Macrophages grouping around an antigen and being transformed into epithelioid cells.

From the Department of Medicine, Section of Hematology, Marshfield Clinic and the Marshfield Medical Foundation, Marshfield, Wisconsin. Publication support provided. Reprint requests to: Joseph J Mazza, MD, Marshfield Medical Center, 1000 North Oak Ave, Marshfield, Wis 54449. Copyright 1979 by the State Medical Society of Wisconsin.

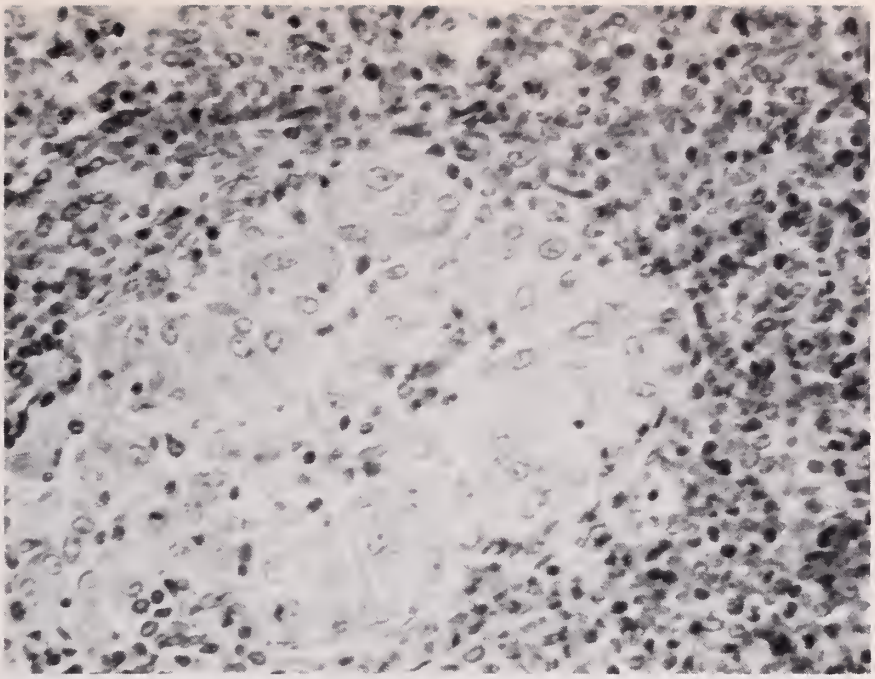
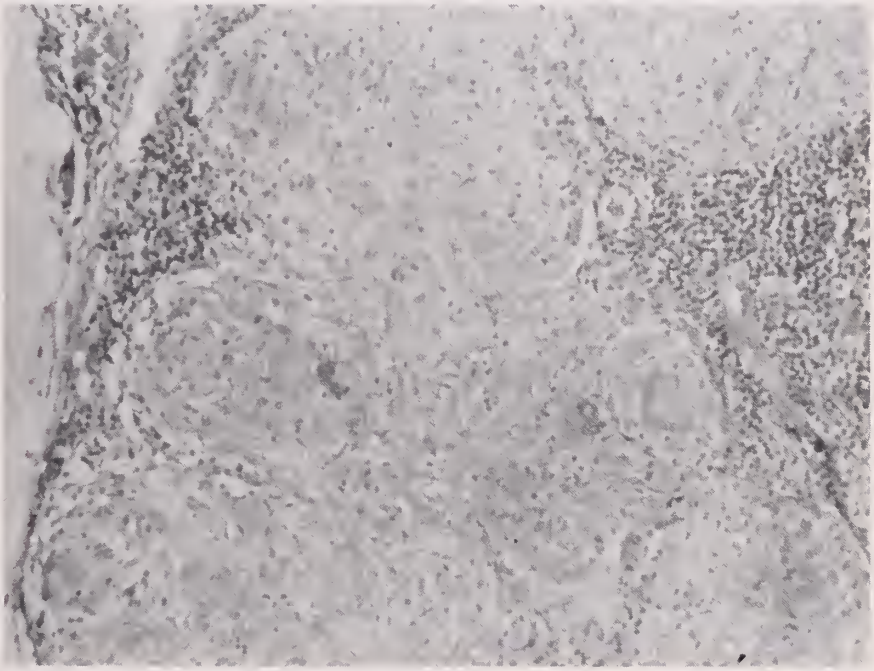
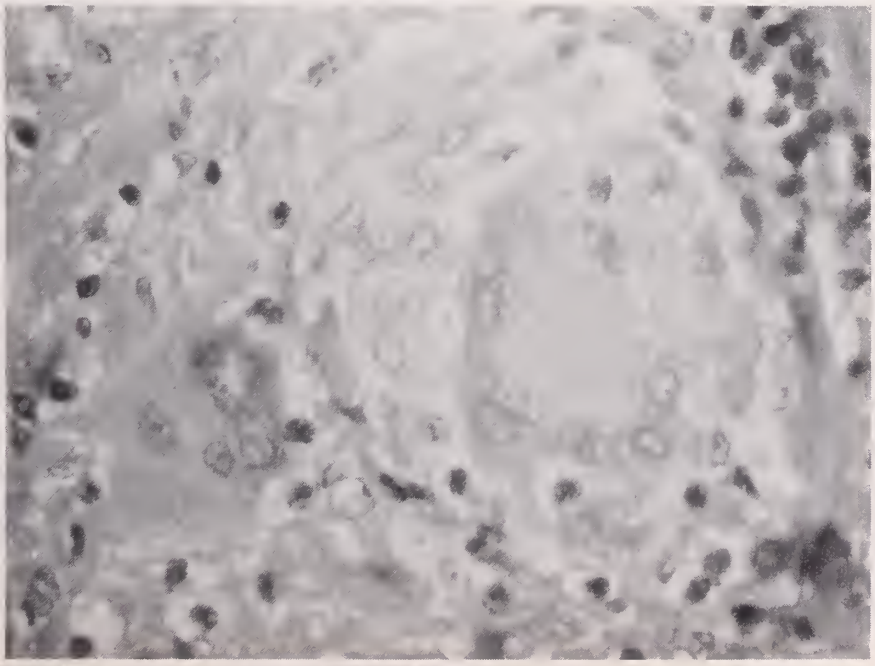


FIGURE 2—Characteristic follicle-like arrangement of epithelioid cells to form a granuloma (mag x480).





FIGURES 3, 4—Giant cells in an epithelioid granuloma formed by coalescence of adjacent epithelioid cells (mag x480, Fig 3; mag x980, Fig 4).

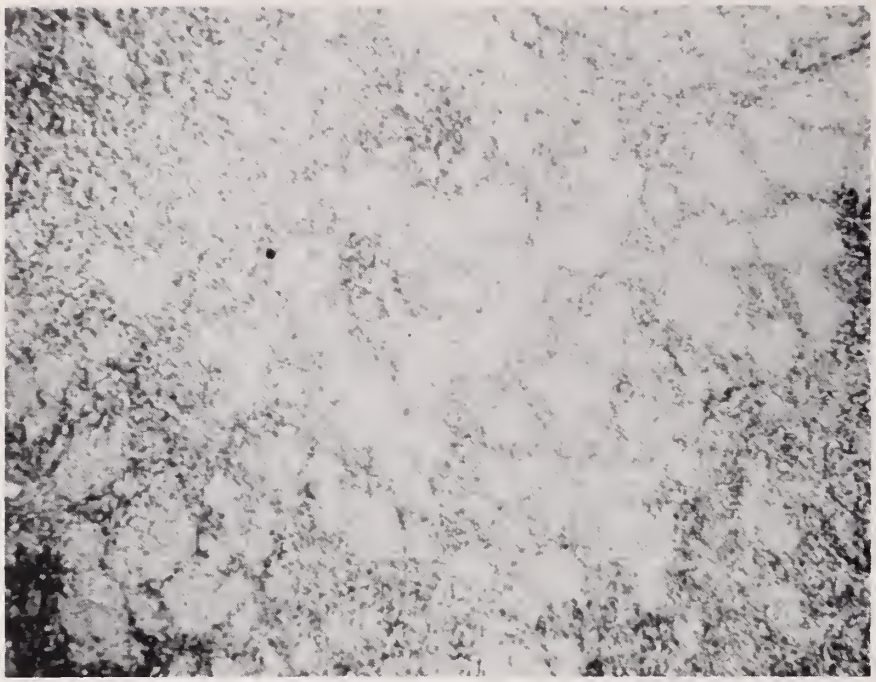


FIGURE 5—Section of a lymph node from a patient with Hodgkin's disease showing extensive involvement of the tissue with multiple epithelioid granulomas (mag x120).

Table 1—Diseases commonly associated with a granulomatous response

Type of agent	Examples of diseases produced
Viral	Infectious mononucleosis, catscratch fever, (thyroiditis, infectious hepatitis??)
Bacterial	Tuberculosis, leprosy, brucellosis
Fungal	Histoplasmosis, coccidioidomycosis, blastomycosis
Parasitic	Schistosomiasis, visceral larva migrans
Inorganic and inert material	Silicosis, berylliosis, asbestosis

References 1, 2, 3, 4

Table 2—Diseases occurring in an immune compromised host associated with granulomatous response

Crohn's disease or granulomatous disease of the bowel
Sarcoidosis
Wegner's granulomatosis
Hodgkin's disease
Primary biliary cirrhosis

References 5, 6, 7, 8, 9, 10, 11, 12, 13

the histopathology of the granulomatous disease process such as one sees in granulomatous arteritis, sarcoidosis, or granulomatous thyroiditis.

There are many organic and inorganic substances which can precipitate a granulomatous reaction. This can occur in many tissues with involvement sometimes being quite extensive (Fig 5). Table 1 lists a few of the more common agents or antigens that we usually associate with granulomatous reactions. The list of various organisms and specific substances which elicit a granulomatous reaction is rather lengthy and not really very helpful in our attempt to discern what factors are important in eliciting a granulomatous response.

However, there appear to be two major factors why granulomatous reactions occur in response to an inciting antigen: (1) The nature of the antigen itself. Poorly biodegradable materials or antigens will elicit a primary granulomatous response by the host. It is felt that because of the inability of the macrophages which are the first line of defense or the primary factor in the afferent limb of the immune system, to handle the antigenic material in an efficient and expedient way, a granulomatous reaction as an alternate type of inflammatory or immune response results. The cell wall of all mycobacteria, the capsule of *Histoplasma capsulatum* and the inert or inorganic materials in Table 1 are examples of poorly biodegradable antigens. (2) The immune status of the host. Is the granulomatous reaction a compromised or secondary type of immune response by a host that is unable to handle the antigenic material because of an altered immune system? This brings into focus those patients with diseases characterized histologically or accompanied by a granulomatous reaction in

whom defective or abnormal cell-mediated immunity has been postulated or demonstrated (Table 2). The etiologic agent or antigen in most of these diseases is unknown, but studies have shown indirect evidence of unrelated persons living in the same environment being sensitized or having been exposed to the same antigen but not developing the disease nor the granulomatous response.[14] In these diseases altered T and B lymphocyte populations have been demonstrated and may be factors in pathogenesis of the granulomatous reaction elicited by the antigen. Again one must ask, is the granulomatous response to certain agents or antigens a sign of a defective cell-mediated immune state of the host?

Summary. There is relatively little known about the role of the granulomatous reaction and how it fits into the spectrum of the immune response by the host. In certain instances or when challenged by specific, poorly biodegradable antigens, it seems to be the appropriate, most effective way for the host to respond. However, it may be a compromised or secondary and less effective response by the host to control the antigen and prevent progression of the disease. Thus, the formation of a granuloma in response to an antigen in some instances might perhaps be an indication of an immune-suppressed state of the host.

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Abstracts

Perirectal abscess in children; a review of 29 cases

ROBERT W KRIEGER, MD and MICHAEL J CHUSID, MD, Milwaukee, Wis: *Am J Dis Child* 133:413-414 (Apr) 1979

The experience with perirectal abscess in children over a 10-year period (1965-1975) at Milwaukee Children's Hospital was reviewed. During this interval 29 cases of perirectal abscess were identified. There was a marked male predominance of cases (79%) and 70% of the children were under five years of age. The most common presenting symptoms were fever, the presence of a mass, and pain. One quarter of the children had a predisposing medical condition, most commonly neutropenia. No patient with inflammatory bowel disease was identified. The microorganisms most often isolated from abscess contents were *S. aureus* (52%), *E. coli* and anaerobes. Blood cultures were usually negative. Typical therapy consisted of incision and drainage of the abscess and a short course of antibiotics. One patient, a leukemic, died. Forty-two percent of the survivors developed complications, either fistula-in-ano (8 patients) or recurrent abscesses (2 patients). These findings suggest perirectal abscess is not an unusual infection in childhood and that this infection may result in significant morbidity. ■

Insulin secretion in the diagnosis of adult-onset diabetes mellitus

ROGER W TURKINGTON, MD and HOWARD K WEINDLING, MD (Diabetes Center, St Francis Hospital, Milwaukee) *JAMA* 240:833-836 (Sept) 1978

The natural history of patients with glucose intolerance was observed in 334 patients during a period of 18 years. Glucose tolerance testing (100 g orally) was characterized by measurement of induced insulin secretion. Diabetic complications of retinopathy, sensory neuropathy, and renal disease developed only in the group of patients in whom the induced serum insulin peak fell below 60 μ U/ml. Preservation of an insulin secretory reserve that permitted serum insulin peaks of 60 μ U/ml or greater was not associated with development of these complications or symptoms of insulin deficiency despite the presence of an equal degree of fasting hyperglycemia and glucose intolerance. A critical amount of insulin secretory reserve distinguishes between two qualitatively distinct clinical syndromes: true diabetes mellitus (the development of signs and symptoms of insulin deficiency) and the syndrome of pure resistance to insulin (signs and symptoms of hyperglycemia in the setting of adequate or excessive insulin secretion, frequently with obesity, but without diabetic complication. ■

REFER TO: Sonek M: Detection and management of early cervical neoplasia in Wisconsin. *Wisconsin Med J* 78:38-40 (Oct) 1979

KEY WORDS: Cervical neoplasia, cytologic diagnosis, colposcopy, PAP smears

Detection and management of early cervical neoplasia in Wisconsin

Mojmir Sonek, MD, Madison, Wisconsin

THE PURPOSE OF THIS study was to assess the status of the detection of early cervical neoplasia, namely cytology and colposcopy, in Wisconsin. At the same time an attempt was made to evaluate the most frequently used procedures in the treatment of early cervical neoplasia. To achieve this questionnaires were sent to all physicians practicing in Wisconsin. Altogether 6,200 questionnaires were sent to the physicians, and completed questionnaires were returned by 1,678 physicians, roughly 27%. Knowing the notorious unwillingness of physicians to complete questionnaires we consider this a success. This also means that figures which are given in this short report are not always statistically accurate because we are dealing with only a percentage of the physicians.

Results. Results of the first question, which asked how many physicians are taking PAP smears in Wisconsin, are given in Table 1. The analysis of Table 1 shows that altogether 156 gynecologists out of approximately 350 answered the questionnaire. This represents 44.5% of all gynecologists practicing in Wisconsin. The answer was as expected, affirmative in all cases. Also there was a relatively high number of family practitioners who answered the questionnaire, and, as expected, almost all of them are performing PAP smears (545 answers out of approximately 1,420, or 40%). Even in the group of other specialties, or where the specialty was not defined, there were 987 answers out of approximately 4,750 which represents more than 20%. The number of physicians in this group performing PAP smears was surprisingly high.

The next question was whether the physicians are sending their PAP smears to Wisconsin cytology laboratories or out of state. Table 2 shows the location of the laboratories that were used for reading the PAP smears. Of 1,066 physicians, 82% (876) of the physicians are using Wisconsin laboratories for reading of their PAP smears. Almost 18% are sending their PAP smears out of state.

The way the readings of the PAP smears were expressed in different laboratories was the subject of the next question. Terminology in reading of the PAP smears is quite important, and our goal was to find out how many physicians are obtaining their results in the current way of reporting and how many are still obtaining the results in the older terminology. In order to clarify this, the

Table 1—Number of physicians performing PAP smears

Specialty	Yes	No	Undefined	Total
Obstetrician-Gynecologist	156	0	0	156
General or Family Practitioner	527	8	0	535
Other or undefined	377	608	2	987
TOTAL	1,060	616	2	1,678

Table 2—Location of the laboratory

Wisconsin		876 (82.7%)
Out of State		184 (17.3%)
New Jersey	33	
Minnesota	31	
California	29	
Oregon	18	
Other	28	
Undefined	45	
TOTAL		1,060 (100%)

From the Departments of Gynecology-Obstetrics and Pathology, University of Wisconsin Hospital and Clinics, Madison, Wisconsin. This paper was supported, in part, from Grant No. CA16405 awarded to Wisconsin Clinical Cancer Center by the National Cancer Institute. Reprint requests to: Mojmir Sonek, MD, UW Hospital and Clinics, 600 Highland Ave, Madison, Wis 53792. Copyright 1979 by the State Medical Society of Wisconsin.

question used in the questionnaire is listed verbatim in Table 3. The number of physicians who are getting the readings in the terms suggestive of expected histopathologic findings (A) or combination of reading in classes and in terms which suggested histologic findings (A-C) is 42%. The terms negative, atypical, suspicious and positive, which seem to be so specific for Wisconsin, are used either alone or in combination with classes in only 26%. The reading in classes alone is still given to 18% of physicians and in 14% there is another combination. The advantages of the readings in the terms suggestive of expected histopathologic findings are explained elsewhere (Sonek).[1] Our goal is to introduce more and more of this kind of terminology in Wisconsin and to replace the old terminology. It is hoped the readings expressed in classes that are obsolete and misleading will be discontinued very soon.

Table 3—"Indicate the modality of PAP smear readings which you receive from your laboratory"

A. Negative - inflammatory changes - mild dysplasia - moderate dysplasia - carcinoma in situ - invasive carcinoma - other	21%
B. Negative - atypical - suspicious - positive	17%
C. Class I, Class II, Class III, Class IV, Class V	18%
D. Combination of A and C	21%
Combination of B and C	9%
Other combinations	14%

Table 4—Number of physicians performing colposcopy (out of 1,060)

	Yes	No	Undefined
Obstetrician-Gynecologist	90	62	4
General-Family Practitioner	9	513	5
Other	5	358	8
Undefined	2	4	0
TOTAL	106	937	17

Table 5—Outpatient treatment of benign disease of the cervix (380 physicians)

Cautery	61%
Cryosurgery	38%
Laser	1%

Table 6—Outpatient treatment of dysplasia and carcinoma in situ (205 physicians)

Cautery	37%
Cryosurgery	60%
Laser	3%

The next series of questions is dealing with the further management of patients with abnormal PAP smears. One question asked whether the physicians were performing colposcopy. The survey results in Table 4 show that 57.6% of the obstetricians and gynecologists perform colposcopy, and in the group of general and family practitioners nine physicians are performing colposcopy.

In the next question we were interested in the biopsy verification of the lesions on the uterine cervix that were detected by abnormal PAP smears. We asked about the use of colposcopy-guided biopsies, conizations or four-quadrant biopsies. Physicians who rely mainly on colposcopically guided biopsies coincided with the percentage of physicians performing colposcopy (approximately 58%). Conization was still performed predominantly by 29% of physicians and four-quadrant biopsy was performed only by 12%.

The last item in which we were interested was the outpatient treatment for cervical neoplasia. The question was: "Which modality (cryosurgery, cautery, laser) was used for treatment of benign diseases and for treatment of dysplasia and/or carcinoma in situ?" (Table 5). Electrocautery is being used predominantly by 60% of physicians. Cryosurgery for benign disease is used by less than 40% and laser by only 1% of physicians.

Of 380 physicians who answered affirmatively the question about outpatient treatment for benign condition or a cervical neoplasia, only 205 are treating dysplasias and carcinoma in situ on an outpatient basis. Sixty percent are using cryosurgery, 37% are using electrocautery, and 3% laser for treatment of these early neoplastic lesions. These percentages are only slightly distorted because 14 records showed that the physicians were using two modalities and one physician used all three modalities for treatment of the early cervical neoplasia.

Conclusion. The results of our survey indicate that the situation with the detection of the early cervical neoplasia and its management in Wisconsin is quite satisfactory. Of the number of gynecologists who answered our poll, 100% are performing PAP smears, the vast majority of family practitioners take the PAP smears and in

addition to that more than 50% of physicians of other specialties are taking PAP smears routinely. Laboratories that perform the service for these physicians are mainly located in Wisconsin. However, a number of physicians send their PAP smears out of state. The situation with the terminology in reading of the PAP smears is quite satisfactory, but there are still many laboratories that report their PAP smears in classes or other obsolete systems. This leads to confusion not only in the statistical evaluation of the PAP smears but also in the management of patients. Our goal is to try to unify this terminology.

The number of physicians who perform colposcopies in Wisconsin is surprisingly high. Of the gynecologists who answered this poll, 58% are performing colposcopies. In addition there are a number of general practitioners and other specialists who use colposcopy. Of 1,060 physicians who answered our questionnaire, 380 physicians are using outpatient treatment for benign diseases of the cervix and 20% are also using outpatient treatment for dysplasia and carcinoma in situ.

Although we do not have the data from other states, in our estimation the practice of detection and treatment of early cervical neoplasia in Wisconsin may be ahead of other states in this country.

Reference

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Abstracts

The effects of air cleaners on hay fever symptoms in air-conditioned homes

JON B KOOISTRA, MD; ROGER PASCH, PE, and CHARLES E REED, MD (Univ of Wisconsin Center for Health Sciences, Madison) *J Allergy Clin Immunol* 61:315-319 (May) 1978

High-efficiency air cleaners that remove 99% of particles greater than 6μ from the air are now available. In an eight-week prospective double-blind crossover study of the efficacy of the addition of these cleaners to home central air conditioning, 20 adults allergic to ragweed or Alternaria, or both, kept daily medication records and symptom scores. The authors recorded daily outdoor pollen and mold counts, bimonthly inside and outside the home pollen and mold counts, and a physician's evaluation of efficacy. When the cleaners were in place, there was a trend toward lower symptom scores and also daytime and evening scores. Only the decrease in symptoms which occurred during night hours were statistically significant. ■

The limited utility of fibrinogen I^{125} leg scanning

RICHARD D SAUTTER, MD; DAVID E LARSON, PA-C; SISIR K BHATTACHARYYA, MD, et al, Marshfield Clinic, Marshfield, Wis: *Arch Int Med* 139:148-153 (Feb) 1979

Using venography as a reference procedure, we examined the utility of fibrinogen I^{125} scintillation scanning for the detection or demonstration of deep venous thrombosis. The study population consisted of 150 patients undergoing total hip replacement who were entered into a double-blind randomized trial pitting sulfinpyrazone and aspirin against a placebo.

Patients were not included for analysis of the utility of fibrinogen I^{125} scanning unless there was complete venographic visualization of the area in question. Our study was somewhat unique in that all patients underwent bilateral venography, either where there were clinical signs and symptoms of deep venous thrombosis, or if the I^{125} scanning remained negative, venography was performed on or about the tenth postoperative day.

Our results demonstrate the inability of scintillation scanning of the leg to determine accurately the presence or absence of thrombi in the deep venous system. Most striking was the lack of sensitivity in areas where the propensity for embolization is greatest, that is, such areas as from Hunter's canal proximal to the inguinal ligament. Of 28 clots formed in this area, only 5 were accurately detected by fibrinogen I^{125} scanning, a sensitivity of 18 percent. Sensitivity is extremely low in all anatomic areas where leg scanning demonstrated reasonable specificity.

It seems appropriate to reexamine the validity of all previous studies which relied heavily or exclusively on leg scanning to determine the incidence of thrombus formation.

Clinicians should be completely aware of the severe limitations described in this report if they are not to abandon leg scanning, the most critical limitation of which is low sensitivity in the area of the deep venous system where thrombi have the greatest propensity for embolization. Clinicians may be lulled into a false sense of security by repeated reports of negative results while thrombus is, in fact, forming. ■

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Cancer Column

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New anti-cancer agents being studied

THE WISCONSIN CLINICAL Cancer Center has recently been awarded a contract for Phase I studies of two very interesting new anti-cancer agents by the National Cancer Institute's Division of Cancer Treatment. Dr Hugh L Davis is the principal investigator and Dr Robert Earhart is the coinvestigator/pharmacologist.

One of the drugs is PCNU, a nitrosourea structurally related to CCNU and methyl-CCNU but more active in animal models. It has the potential for being more valuable in the treatment of brain tumors because of its better penetration into the cerebrospinal fluid.

Sixteen patients have been treated to date with PCNU. Thrombocytopenia is the only sign of toxicity which has been observed. It is planned to continue escalating the dosage administered until a dose-limiting toxicity is reached. The investigators would like to study this drug in 10 to 15 more patients who have solid tumors which are refractory to conventional therapy, who have an estimated life expectancy of at least 18 weeks, and who have reasonably normal organ function.

The second drug which is being studied is ICRF 187, a water soluble enantiomer of racemic ICRF 159 which is poorly absorbed from the gastrointestinal tract. ICRF 187 has shown activity in animal studies. It was selected for Phase I study because it can be given intravenously. The drug is being given to patients as a 48-hour continuous infusion; so far the amount which has been administered is not close to the maximum tolerated dosage. The investigators would like to study this drug in at least another 20 to 25 patients with various types of cancer, reasonably normal organ function, and an expected survival of at least 12 weeks.

Referrals for these or future Phase I studies will be appreciated. These will be strictly investigative studies whose primary purpose will be to determine the safe dosage of the new drug in man. Evaluation of anti-tumor activity will be secondary in these studies.

The studies with PCNU will require hospitalization for five to six days every six weeks. Those with ICRF 187 will necessitate hospitalization for about three days every three weeks. Interim blood counts and observations can be performed by the patient's personal physician.

If you would like further information about these Phase I studies, please contact Dr Hugh Davis at 608/263-8608 or Dr Robert Earhart at 608/263-5380, or any staff physician of the Clinical Oncology staff of the WCCC.—DOROTHY J BUCHANAN-DAVIDSON, PHD, Science Writer

Visiting Fellowships in General Medical Oncology
for Internists and Family Physicians

Visiting Fellowships or "mini-residencies" in General Medical Oncology are now available for the primary-care physician who has a special interest in the management of patients with cancer. The Divisions of Clinical Oncology and Radiation Therapy of the Wisconsin Clinical Cancer Center are offering each Visiting Fellow a wide variety of learning experiences from which he or she may select those most suited to personal and practice requirements.

The main objective of the Fellowship will be to learn more about current diagnostic, staging, therapeutic, and followup procedures which are being used at WCCC. During the week the physicians should gain an appreciation of the complexities involved in the management of cancer patients and improve their own skills. They also

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center. 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

will become familiar with the resources which are available at WCCC to assist primary-care physicians in cancer patient management.

The Visiting Fellows will make rounds with the attending clinical oncologists and attend oncology clinics (Chemotherapy, Leukemia/Lymphoma, Gynecology Tumor, Breast Tumor, Pediatric Oncology, and Mammography). Special procedures such as lymphangiography and arterial infusions will be demonstrated. The physicians also will be able to attend teaching conferences in Diagnostic Radiology, Nuclear Medicine, Radiotherapy Planning, Gynecology Oncology, Oncology Pathology, New Patients, Oncology Grand Rounds, Medical Grand Rounds, and Family Practice Grand Rounds. The resources of the William S Middleton Health Sciences Library will be available for individual study.

Although most physicians will complete the Fellowship in one week, those who wish more experience may enroll for two weeks. Fellowships will be scheduled Monday through Friday from October through April. Only two physicians will be enrolled each week so that personal attention can be given to each. The registration fee will be $250 for one week or $400 for two weeks and will cover the cost of instruction and educational materials. The individual physician will be responsible for the cost of food and housing in Madison.

Completion of the one week Fellowship will earn the participant 40 hours of AMA Category I Continuing Medical Education credit. Forty hours of AAFP prescribed credit have been applied for. Completion of the two-week Fellowship will double the amount of credit earned.

If a physician is interested, he or she should contact Dr Paul C Tracy at 608/263-3455 or Ms Lois Barker at 608/263-2861.—DOROTHY J BUCHANAN-DAVIDSON, PHD, Science Writer ■

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Through orthopedic field clinics, the Bureau for Children with Physical Needs (BCPN) provides diagnostic examinations and consultation for persons under 21 years of age, primarily in areas where orthopedic consultation is not readily available.

Referrals may be made to BCPN by family physicians, nurses and therapists, who may attend the clinic if they desire, and will receive reports following clinics.

REFERRAL FORMS: Should be obtained from BCPN (see below) and returned to us *well in advance* of the clinic date. We need to know the number of children to be seen at clinic so that we may schedule appointments and notify parents and others of the clinic appointment time and date and invite them to attend.

Children should be screened carefully to determine the need for an orthopedic examination and that they are not already under the care of an orthopedist.

Please complete *all* information on the referral form. Under "Reason for Referral" describe the *specific* condition. In the blank space in the upper left hand corner, please indicate the name and address of the referring agency or person.

ADDRESS CORRESPONDENCE TO: BUREAU FOR CHILDREN WITH PHYSICAL NEEDS, 126 Langdon St, Madison, WI 53702. Tel: 608/266-3726

REQUEST _____ clinic referral forms
number

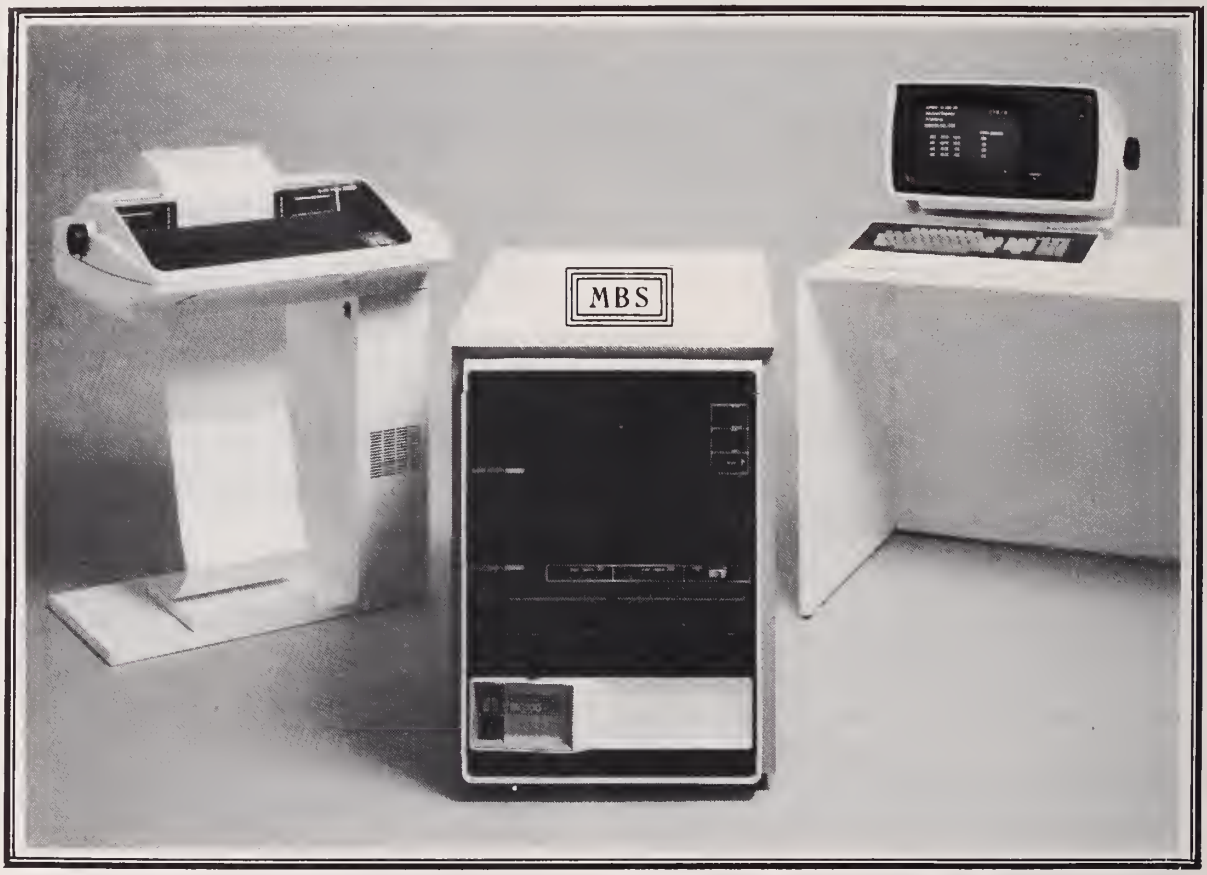
for _____ orthopedic clinic on

_____. NAME AND ADDRESS
date

OF REFERRING AGENCY _____

_____

Because It's Time . . .



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Organizational SMS

SMS/DHSS to cooperate in Medicaid medical audits

The SMS Council on September 8 took steps to establish a Medicaid Medical Audit Committee between the State Medical Society of Wisconsin and the Wisconsin Department of Health and Social Services (DHSS). Under the "Contract for Professional Medical Services" approved by the Council, the SMS Commission on Mediation and Peer Review will review selected cases directed to it by DHSS regarding quantity, quality or appropriateness of medical care furnished by a provider under the Medical Assistance Program. It is expected that the Commission will review approximately 12 cases a year under this contract.

In other action at its September 8 meeting the Council:

- Heard a presentation on the organization and operation of Health Maintenance Organizations (HMO) and Individual Practice Associations (IPA) in Wisconsin along with an analysis of both problems and opportunities associated with their development.

- Approved a recommendation from the SMS Committee on School Health that the Society sponsor a runners' clinic in conjunction with the Madison Marathon Association's running event in June 1980. This clinical session will be aimed at runners, physicians, physical fitness instructors, and track coaches and will include topics on treatment and rehabilitation of common running injuries, prevention of injuries, exercise physiology, and others.

- Received a report from the Ad Hoc Committee on Women's Health Issues detailing the Committee's suggested action on more than 60 recommendations emanating from the Women's Health Issues Conference last April. The Council directed the Committee to distribute the recommendations to the appropriate SMS commissions and committees for further consideration before Society policy is established.

- Approved a dues increase from $5 to $15 for SMS Resident Membership, to be effective in 1981 pending approval by the SMS House of Delegates in March 1980.

- Approved a request by the Committee on Alcoholism and Other Drug Abuse that that committee explore continuing medical education programs in the field of alcoholism and drug abuse for dissemination to physicians.

- Appointed Robert A Starr, MD., Viroqua, to serve on the Cost Containment Committee.

- Approved a request by the Commission on Continuing Medical Education to hold the SMS Annual Meeting in Milwaukee from 1982 through 1992 utilizing MECCA and the new Hyatt Regency as the headquarters hotel on the following dates: May 13-15, 1982; March 24-26, 1983; March 29-31, 1984; March 28-30, 1985; April 17-19, 1986; March 26-28, 1987; April 28-30, 1988; April 13-15, 1989; April 26-28, 1990; April 18-20, 1991; April 23-25, 1992. Dates previously set are March 28-29, 1980 and March 27-28, 1981.

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

November 15— A day to quit smoking

the great american smokeout

The third annual Great American Smokeout has been set for Thursday, November 15, the American Cancer Society has announced. The logic behind the Great American Smokeout is that if people discover support is available from their peers and the Cancer Society, and they successfully quit smoking for one day, perhaps they will try again, for a longer time. Smokers are asked to sign pledge cards stating they will not smoke on November 15, 1979. The card serves as a reminder of their commitment. Physicians are urged to support the smokeout in their offices and make use of pledge cards, posters, payroll stuffers, buttons, and other support materials in their offices. For more information, contact local county units of the American Cancer Society or the Wisconsin Division office at 611 N Sherman Avenue, Madison, Wisconsin 53704; phone: (608) 249-0487. ■

GAC opposes x-ray bills, suggests alternatives

Stating the legislation was premature in light of a Health Policy Council study already underway on radiation and health in Wisconsin, the State Medical Society's Commission on Governmental Affairs in September went on record as opposing Assembly Bill 824, a bill requiring certification of all x-ray machine operators in the state.

Appearing before the Commission at its September 12 meeting was AB 824's chief author, Rep David Travis (D-Madison). The Commission suggested the following alternatives to Rep Travis in lieu of legislation: (1) allow the State Department of Health and Social Services to "beef-up" present x-ray equipment inspections; (2) institute a minimum training level for x-ray operators; and (3) establish a continuing education requirement for x-ray machine operators on a yearly basis.

SMS currently is conducting meetings with legislators to pursue the possibility of drafting a substitute amendment to AB 824 or a different piece of legislation.

In other action the Commission:

- Supported two bills, AB 439 and SB 220, which would establish a mandatory risk-sharing pool for persons unable to obtain health insurance coverage on the voluntary market because of unfavorable underwriting or policy exclusion. Furthermore, under AB 439, persons eligible for the risk-sharing pool who also have low incomes, the so-called "working poor," would be eligible for a state subsidy to ensure their access to necessary medical care. The Commission suggested that SB 220 be amended to include this low income provision.

- Endorsed AB 438 creating a catastrophic illness insurance plan whereby persons incurring heavy medical expenses may obtain state aid in meeting their abnormally large financial responsibilities. The bill establishes standards of eligibility, requires personal payment of a defined sum before state aid would be administered, and limits the types of healthcare services for which state benefits would be paid.

- Supported AB 780 which requires every health insurance policy that provides coverage for hospital emergency room treatment contain a clause excluding from coverage the first $6 of costs for emergency room services. The Commission recommended that the bill, designed to address the problem of over-utilization of emergency rooms, be expanded to include Medicare and Medicaid.

- Supported AB 751 and SB 283 which establish a rabies control program through revision of the state's dog licensing laws.

President Treffert nominated to MEB study committee

SMS President Darold A Treffert, MD, Fond du Lac, has been nominated to serve as the State Medical Society's representative on a study committee which may be appointed by the State Medical Examining Board to look into old age impairments of physicians, how extensive the problem is, and how best to deal with it. The MEB believes there may be a need for competency tests for older doctors. Since announcement of the MEB's thinking, William Baker, MD of Monroe, MEB chairman, said he has had almost no reaction from doctors. President Treffert would welcome doctors' viewpoints on this issue. Call SMS offices in Madison: 1-800-362-9080 toll-free or 257-6781 in the Madison area.

President Treffert to author newspaper health column

Starting in October SMS President Darold A Treffert, MD of Fond du Lac will author "Health Caring," a weekly column distributed by SMS to Wisconsin newspapers offering health tips for readers on a variety of subjects. Doctor Treffert succeeds Victor S Falk, MD of Edgerton, who began the column in May 1978 as a project of the SMS Commission on Public Information. Currently more than 70 Wisconsin weekly and daily newspapers publish the column.

Deadline approaching for Speakers Awards entries

Physicians have until Nov 15, 1979 to submit their entries to the 1979 AMA National Awards Program for Medical Speakers. Any physician-speaker representing his or her state or county medical society in one of seven audience categories may submit, with no entry fee, one standard size audio or video cassette tape for any or all of the categories. The categories are: television news show (video cassettes only); television talk show (video cassettes only); radio news or talk show; the physician as TV or radio host; public (lay) audience speech; testimony (tapes preferred, but transcripts accepted). Creativity and effectiveness of messages content as well as delivery style will be evaluated as a basis for selecting winners. For more information contact Mr Mortimer T Enright, AMA, 535 N Dearborn St, Chicago, Illinois 60610; or Diane Upton at SMS Madison offices: 257-6781, or toll-free 800-362-9080. ■

Attention physicians: Reduced practice membership classifications

The Society reminds physicians who have reached age 65 and practice 1,000 hours or less during the calendar year, but do not qualify for associate membership, may apply for a "senior" membership which waives 50 percent of the regular membership dues.

This special membership classification must be applied for through the physician's county or state society. The change will become effective January 1 following receipt of the request.

In addition, the Society reminds physicians who are over 70 years old that they are not required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

The dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues-exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification (less than 240 hours of practice per year) which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classifications can be arranged. ■

Move slowly on patient package insert, Dr Treffert writes FDA

The President of the State Medical Society of Wisconsin, Darold Treffert, MD, Fond du Lac, urged the Federal Food and Drug Administration September 10 to move slowly on its proposal to require patient package inserts (PPI) in all dispensed prescription drug products and to first study the proposal's effectiveness on a pilot project.

In a statement Doctor Treffert forwarded to a public hearing on the PPI in Chicago at the request of the SMS Council, he questioned whether the proposal, which is estimated at costing almost a billion dollars, would be the best vehicle for providing patients with drug information.

"Mass distribution might actually do harm in terms of unnecessary fear, iatrogenic hypochondriasis, and further erosion of patient compliance," Doctor Treffert wrote. "The PPI lacks perspective and relative risk: benefit ratio information that only a knowledgeable health professional or practitioner can provide." ■

Wisconsin AMA Delegates active in national scene

John K Scott, MD, Madison, AMA Delegate, has been appointed by the Speaker of the AMA House of Delegates to Reference Committee B (Legislation) for the 1979 Interim Meeting in Hawaii, December 2-5. Delegate Patricia J Stuff, MD, Bonduel, has been appointed to chair the AMA Ad Hoc Committee on Women Physicians in Organized Medicine. The purpose of this one-year committee is to develop specific recommendations and mechanisms to insure the involvement of women physicians at all levels of organized medicine.

New membership classifications for young physicians

Many young physicians are eligible for a special membership classification at the State Medical Society which carries with it a reduction in membership dues.

Any physician who has been a member of a state medical society for the preceding 12 months and is elected to membership in this society within six months of completing residency, fellowship, or fulfillment of government obligation enjoys a dues reduction of 50 percent the first year and 25 percent the second year.

This society and most other state medical societies have a special membership classification for Residents which has a very low dues structure.

The AMA, to attract new members, has a new physician membership classification. Under this membership classification a new physician in his first full year of practice is eligibile for a 50 percent reduction in AMA dues for one year.

New physicians are urged to seriously consider joining organized medicine as early as possible to take advantage of these special membership rates. ■

Medical Liability

SMS MDs help formulate WHCLIP premium levels

The Board of Governors of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) continues to have substantial input from physicians. Actions taken by the Board relative to premiums are based upon recommendations of the Actuarial/Underwriting Subcommittee. While the subcommittee is dominated by representatives of the insurance industry, two physicians, Dr Russell Quirk (Chairman of the Medical Liability Committee of the Physicians Alliance, State Medical Society) and Dr Paul Jacobs (also a member of the Medical Liability Committee of the Physicians Alliance) are also members and played significant roles in formulating the recommendations subsequently approved by the Board.

Among the recommendations approved by the Board of Governors were:

1. Maintaining WHCLIP premiums at the current levels.

Although past experience of WHCLIP indicates a necessary increase of 24.1% in premium levels, the amount of investment income to be earned on WHCLIP reserves and transfer of unused reserves from 1975 and 1976 is enough to offset the need for additional premiums this year. The WHCLIP actuary has warned, however, that if:

a. current trends regarding the number of claims filed and amounts awarded continue, and

b. the reserves are depleted, then

c. a sizeable increase in premiums (approximately 31%) will be required next year. This warning appears to be based on forecasting trends which in the past have proven to be unpredictable. Nevertheless, some increases in premiums may occur next year. The Medical Liability Committee of the Physicians Alliance and Actuarial/Underwriting Subcommittee will continue to monitor this carefully.

2. Raising the Patient Compensation Fund fee assessment from 6% to 10% of the WHCLIP premium.

This action restores the fee to the level at which it was originally set and does seem justified as more claims are penetrating the fund.

3. Reducing the Patient Compensation Panels fee from $40 to a sum sufficient to administer the Panels.

Currently the Panels have a budget of $208,000 per year and has $1,297,000 in its investment fund. Thus fees of $40 per physician are not necessary.

4. Eliminating the Radiology and Pathology department head surcharge.

In the past WHCLIP assessed an additional premium against these department heads due to the vicarious liability acquired through supervising hospital staff members. However, experience has shown that this added liability is negligible and does not warrant an additional charge.

5. Reducing the partnership and service corporation surcharge from 5% to 2.5%.

In previous years this had been reduced from 20% to 10% to 5%. Again, experience is proving this additional charge unnecessary.

6. Providing coverage for allied health care personnel employed by physicians. This coverage is optional and will be available from WHCLIP only through the physician/employer policy and at rates less than those charged by private insurers who offer individual policies to allied health care personnel.

The efforts of the Medical Liability Committee of the Physicians Alliance, comprised of Doctor Quirk (Racine), Doctor Jacobs (Milwaukee), Dr Fred Kriss (Madison), Dr Norman Becker (Fond du Lac), Dr Walter Moritz (Ft Atkinson), and Dr Eugene Nordby (Madison), as well as the effectiveness of Doctors Quirk and Jacobs on the Actuarial/Underwriting Subcommittee and Doctor Nordby on the Board of Governors, have created a manner of dealing with malpractice issues whereby both the insurance and medical professions are represented. It is doubtful that the Board of Governors' recommendations would have reflected physician concerns had it not been for the work of the Medical Liability Committee of the Physicians Alliance.—KENNETH M VISTE JR, MD, Chairman, Physicians Alliance Commission ■

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of September 4, 1979

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/subspecialty)

County Medical Society

MILWAUKEE

Chambers, Charles H, 11402 W Wisconsin Ave, Wauwatosa 53226 (1943, Resident, Emergency Medicine/Pediatrics, Certified-PD)
Goldman, Stuart L, 610 N 19th St, Milwaukee 53233 (1950, Resident, Family Physician)
Krieg, E Michael, 1031 N Astor, Milwaukee 53202 (1940, Regular, Orthopedic Surgery, Certified)
Martinez, Francisco, 9065 W Waterford Sq N, Greenfield 53228 (1949, Resident, General Surgery)
McClellan, Stephen L, 3407 N 88th St, Milwaukee 53222 (1949, Resident, Pathology)
Mendiola, Rolando M, 8860 Greenview Lane, Greendale 53129 (1947, Regular, General Surgery/Cardiovascular Surgery)
Riendl, Anne M, 2171 N 40th St, Milwaukee 53208 (1949, Resident, Obstetrics and Gynecology)
Silver, Ted S, 811 E Wisconsin Ave, Suite 930, Milwaukee 53202 (1949, Regular, Cardiovascular Diseases/Internal Medicine)
Weber, Jeffrey M, 5757 W Oklahoma Ave, Milwaukee 53219 (1948, Regular, Gastroenterology/Internal Medicine, Certified-IM)
Wilkins, Terrence J, 400 W Silver Spring Dr, Milwaukee 53217 (1946, Regular, Plastic Surgery)
Woods, R John, 2956 N 50th St, Milwaukee 53210 (1946, Resident, General Surgery)

ONEIDA-VILAS

Ritter, Carol A, PO Box 470, Woodruff 54568 (1950, Regular, Pathology, Certified-PD)

RUSK

Romeis, Richard J, 906 College Ave, W, Ladysmith 54848 (1949, Regular, Internal Medicine, Certified-CRS)

VERNON

Bender, William L, Rte #1, Viroqua 54665 (1942, Regular, Emergency Medicine)

WAUKESHA

Chumbley, Clyde M II, W180 N7959 Town Hall, Menomonee Falls 53051 (1949, Regular, Obstetrics and Gynecology)
Neils, Richard E, 2856 Interlaken Dr, Oconomowoc 53066 (1948, Regular, Dermatology/Internal Medicine, Certified-IM)

WOOD

Billings, Kenneth J, 800 S Drake Ave, Marshfield 54449 (1939, Regular, Radiology, Certified)
Speltz, Stephen M, 1000 N Oak Ave, Marshfield 54449 (1948, Resident, General Surgery)

CHANGE OF ADDRESS

(Does not include those within a city)

BROWN

Troup, Ralph L, De Pere, to 1130 North Westfield, Oshkosh 54901

CHIPPEWA

Ceniza, Silverio Jr, Chippewa Falls, to 116 Lumpkin St, Hawkinsville, GA 31036

DANE

Demling, Robert H, Madison, to 4301 X Street, Sacramento, CA 95817
Ebaugh, Duane W, Monona, to 7 Pilot Point Rd, Cape Elizabeth, ME 04107
Hausserman, Sue A, Madison, to 308 E 14th St, Kaukauna 54130

GREEN

DeWaal, Jan G, Monroe, to 1202 6th St, South Boston, VA 24592

MILWAUKEE

Quiroz, Francisco A, Milwaukee, to Ayuntamiento 45, Col Coyoacan, Mexico 21 of Mexico
Redlin, Russell R, Waterford, to 77-500 Interstate 10, Indio, CA 92201

OUTAGAMIE

Austin, Robert J, Appleton, to 619 Edgemoor, Kalamazoo, MI 49008
Bolan, Robert K, Hartland, to 2252 Fillmore St, San Francisco, CA 94115

DEATHS

Caldwell, William L, Dane County, May 21, 1979
Jeffers, Dean H Jr, Walworth County, July 26, 1979
Weir, James R, Green County, Aug 4, 1979
Weber, John C, Dodge County, Aug 5, 1979
Werra, Bernard J, Waukesha County, Aug 16, 1979
Kash, Sarkis H, Milwaukee County, Aug 18, 1979 ■

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Obituaries

◈County, State, AMA Members

◈ **Dean H Jeffers, Jr, MD,** 59, Lake Geneva, died July 26, 1979 in Lake Geneva. Born May 26, 1920 in West Salem, Doctor Jeffers graduated from Marquette University School of Medicine in 1951, had practiced in the Lake Geneva area since 1952 and was a member of the medical staff of Lakeland Hospital. He was medical adviser for Lake Geneva Area schools and also medical supervisor for the Blood Bank in the area. During World War II he served in the United States Army from 1941 - 1945. Surviving are his widow, Catherine; two daughters, Lucretia and Sara; and a son, Dean, all at home.

"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

Eli Lilly & Co distributing Darvon® patient leaflets

Risks associated with the use of Darvon® (propoxyphene) products have prompted Eli Lilly & Co to distribute a patient information leaflet to pharmacists asking them to distribute it each time they dispense a prescription for Darvon®. The Walgreen Drug Co is notifying physicians that distribution of this leaflet, according to Walgreen, may "cause some patients to become unduly, apprehensive about the safety of the drug prescribed by their physicians." Walgreen suggests that physicians discuss the leaflet with the patient before writing the prescription in order to prevent undue apprehension on the part of the patient and to minimize calls to the physician by the patient regarding the drug. Physicians interested in seeing a copy of the Darvon® leaflet should contact Eli Lilly & Co, Walgreen Co at 200 Wilmot Road, Deerfield, Illinois 60015, or their local pharmacist. ■

◈ **Rowland W Leiby, Jr, MD,** 61, LaCrosse, died July 28, 1979 in LaCrosse. Born Sept 29, 1917 in Raleigh, NC, Doctor Leiby graduated from the University of Rochester School of Medicine in 1942. He had been associated with the Gundersen Clinic from 1953 until his retirement in 1976 in the Department of Obstetrics and Gynecology. He was a member of the American College of Obstetricians and Gynecologists. He served in the United States Army from 1943 - 1946 and was discharged with the rank of Major. Surviving are his widow, Mary Kathleen; one daughter, Susan Kay Peterson, San Antonio, Tex, and one son, Peter K of Chicago.

◈ **James Robert Weir, MD,** 60, Monroe, died Aug 4, 1979 in Monroe. Born Oct 18, 1918 in Waukesha, Doctor Weir graduated from the University of Illinois Medical School in 1943. He was a member of the Monroe Clinic and served as chairman of the Department of Obstetrics of St Clare Hospital for many years. He also had served as chief-of-staff of the hospital. In 1974 he was honored as "Outstanding Senior Citizen" by the Monroe Jaycees. Surviving are his widow, Geraldine; four sons, James R, South Wayne; Donald G, Madison; Glen O, Augusta, Ga; and Timothy J, Oregon; and two daughters, Mrs John (Christine) Cramer, Peekskill, NY and Carolyn of Madison.

◈ **John Carl Weber, MD,** 49, Beaver Dam, died August 5, 1979 at Elkhart Lake. Born Apr 24, 1930 in Sheboygan, Doctor Weber graduated from the University of Wisconsin Medical School, Madison, in 1955. He served for two years in the United States Air Force in Germany and was a fellow in radiology at the Mayo Clinic from 1959 - 1962. He was a member of the medical staff at Columbia Hospital, Milwaukee, from 1964 - 1977 when he became associated with the Radiology Associates of Beaver Dam, Ltd. Surviving are his widow, Millicent; a son, John Jr and a daughter, Brynn, Beaver Dam.

Fred Hammerli, MD, 76, North Hollywood, Calif, died Aug 12, 1979 in North Hollywood. Born Dec 5, 1902 in Mount Rose Township, Dane County, Doctor Hammerli graduated from the University of Wisconsin Medical School, Madison, in 1933. He had been practicing medicine in California since 1940 and had retired in 1970. He is survived by a sister, Anna Maria Hammerli of North Hollywood, Calif.

Irving Auld, MD, 81, Clintonville, died Aug. 16, 1979 in Clintonville. Born Oct 26, 1897 in Billingham, Wash, Doctor Auld graduated from Northwestern University School of Medicine, Chicago, Ill, in 1929. He served in the United States Navy during World War I. Doctor Auld had practiced medicine in Clintonville since 1930 and was instrumental in opening the hospital. Surviving are his widow, Dorothy; and one daughter, Elizabeth Smith of Jackson, Wy. ■

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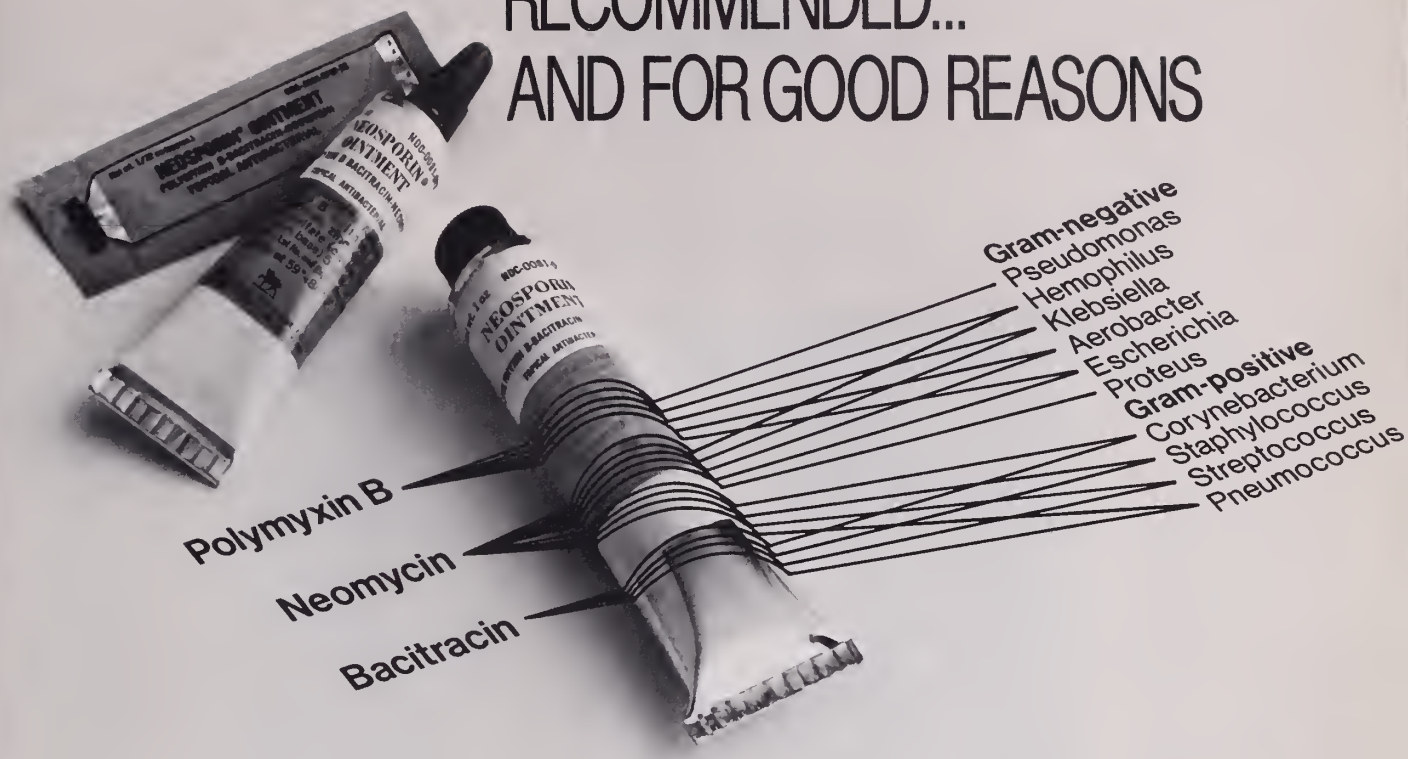

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Specialty Societies

WISCONSIN SOCIETY OF INTERNAL MEDICINE: Michael J Mally, MD, Hartford internist, was installed as president of the Wisconsin Society of Internal Medicine during the group's annual meeting and scientific program at Lake Geneva, Sept 14 and 15. He succeeds John P Mullooly, MD of Milwaukee. Doctor Mally served as the society's secretary-treasurer in 1977 and as president-elect last year. He was elected to the governing council in 1976. Prior to that he served as chairman of the society's peer review and legislative committees. He currently is a delegate to the American Society of Internal Medicine. Others elected are president-elect—Kenneth I Gold, MD, Beloit; secretary-treasurer—Joseph E Mazza, MD, Marshfield; and Russell A Quirk, MD, Racine, to a 3-year term on the governing council. As outgoing president, John P Mullooly, MD, will continue as a council member along with Philip J Dougherty, MD, Menomonee Falls, George E Magnin, MD, Marshfield, and Anthony P Ziebert, MD, Milwaukee. Serving as an ex-officio member of the council is Charles L Junkerman, MD, Milwaukee, who is the American College of Physicians' governor for Wisconsin.

WISCONSIN NEUROLOGICAL SOCIETY: The Twenty-third Meeting of the WNS will be held at the Heidel House, Green Lake, on Friday and Saturday, October 26 and 27. The meetings are open to all interested physicians and all allied health personnel. Further details appear in the YELLOW PAGES section of this issue. Officers of WNS are: Raymond W M Chun, MD, Madison, president; Phiroze L Hansotia, MD, Marshfield, president-elect; Michael P McQuillen, MD, Milwaukee, vice-president; Gamber F Tegtmeyer, Jr, MD, Madison, secretary-treasurer; and Francis M Forster, MD, Madison, secretary for continuing medical education.

AMERICAN COLLEGE OF SURGEONS, WISCONSIN CHAPTER: The fall annual meeting of the Wisconsin Chapter to ACS will be held Saturday, November 3, at the Olympia Resort and Spa in Oconomowoc. Program planners are hopeful that Governor Dreyfus and other individuals on the political scene will speak at the day-long conference. Current officers are: president—John K Scott, MD, Madison; president-elect—Stuart D Wilson, MD, Milwaukee; vice president—J David Lewis, MD, West Bend; secretary-treasurer—Thomas M O'Connor, MD, Milwaukee. Councilors are: Elizabeth A Steffen, MD, Racine; David T Uehling, MD, Madison; Kendall E Sauter, MD, Wauwatosa; and John M Mills, MD, Green Bay. Governors are: Bruce J Brewer, MD, Milwaukee; and Wayne J Boulanger, MD, Milwaukee.

WISCONSIN SOCIETY OF PATHOLOGISTS: The 1979 Annual Fall Meeting of the WSP, in association with the State Medical Society Section on Pathology, will be held Saturday, November 10 at the Clinical Sciences Center (new University Hospitals) in Madison. Details of the program appear in the YELLOW PAGES section of this issue.

WISCONSIN ALLERGY SOCIETY: Officers of the WAS elected September 9 during the Annual Meeting in Oshkosh are: MDs Morton M Soifer, (Bayside) Milwaukee, president; William W Busse, Madison, president-elect; and Martin Z Fruchtman, Waukesha, secretary-treasurer.

WISCONSIN ACADEMY OF FAMILY PHYSICIANS: Further elections at the WAFP's annual meeting this summer, as reported in the September issue of *The Wisconsin Family Physician* newsletter are as follows: MDs Jack Strong, Mauston—speaker, and Thomas H Peterson, Wausau—vice-speaker, of the Congress of Delegates. Henry M Goldberg, MD, Milwaukee, was elected to a three-year term on the Board of Directors. John W Beasley, MD, Brooklyn, was elected to a one-year term. Reelected to the Board for three-year terms were MDs Lief Erickson, Burlington, and Francis Schammel, Stoughton. Holdover members of the Board are: MDs Norman Schroeder, Manitowoc; James Esswein, Chetek; Donald Lindorfer, Milwaukee; John Bollinger, Eau Claire; Martin Janssen, Friendship; and James Moore, Verona, who also was elected chairman of the Board. John Peters, MD, Fond du Lac, was reelected a delegate to the AAFP. Donald Heyrman, MD, Menomonee Falls, was reelected his alternate. William Wright, MD, Mondovi, was elected as alternate delegate for Richard Shropshire, MD, Madison. (See also September issue of WMJ)

Several resolutions presented and approved at the Congress of Delegates included two resolutions specifically dealing with the Family Practice Department at the University of Wisconsin. One called for

an advisory committee to assist the department in intradepartmental or interdepartmental problems. The other asked that the report of the Faculty Advisory Committee be made public by August 1, or else recommended that the Legislature conduct an investigation into Dr John Renner's resignation.

Other resolutions called for: an increase in family practice education at the undergraduate level at both medical schools; liaison with family physicians in private practice by the medical school residency programs; a commendation for Dr Wallace Mathews, chairman of the AAFP Board of Directors, who spent time in Madison reviewing the reasons surrounding the resignation of Doctor Renner; a recommendation that the UW Medical School hire a chairman of the Department of Internal Medicine who is sympathetic towards Family Medicine; a commendation for the Medical College of Wisconsin for its commitment towards the education of Family Physicians; a recommendation that the Legislature and the medical schools provide scholarship funds for medical students from underserved, rural areas; a recommendation that medical school administrations encourage their faculty in all departments to promote family medicine; a suggestion that the AAFP take a leadership role in migrant worker health care; and a motion to amend AAFP policy statements regarding hospital privileges for Family Physicians. ■

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(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

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9-4672 (Y957A)

Overweight may not always be simple... complications can develop.*

Complicated or not...

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(diethylpropion hydrochloride NF)

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A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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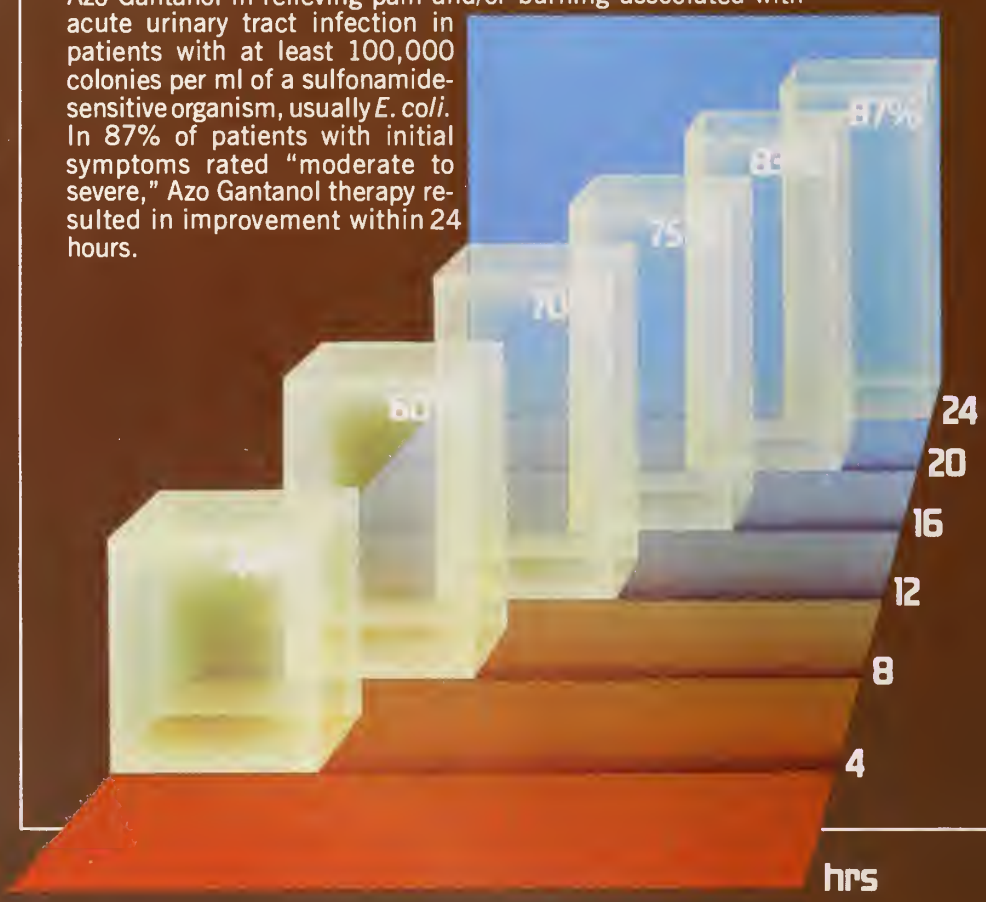
For prescribing information see opposite page.

Important data on the pain of acute cystitis:

In 87% of patients studied (303 of 349), Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain **for the pathogens**

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Before prescribing, please consult complete uct information, a summary of which follow

Indications: In adults, urinary tract infectio complicated by pain (primarily pyelonephri pyelitis and cystitis) due to susceptible orga (usually *E. coli, Klebsiella-Aerobacter, Stap coccus aureus, Proteus mirabilis,* and, less quently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Not fully coordinate *in vitro* sulfonamide sensiti tests with bacteriologic and clinical respon aminobenzoic acid to follow-up culture me increasing frequency of resistant organisms the usefulness of antibacterials including s fonamides.** Measure sulfonamide blood lev variations may occur; 20 mg/100 ml shoul maximum total level.

Contraindications: Children below age 12; fonamide hypersensitivity; pregnancy at ter during nursing period; because Azo Gantan tains phenazopyridine hydrochloride it is c dicated in glomerulonephritis, severe hepa uremia, and pyelonephritis of pregnancy w disturbances.

Warnings: Safety during pregnancy not est Deaths from hypersensitivity reactions, ag tosis, aplastic anemia and other blood dys have been reported and early clinical signs throat, fever, pallor, purpura or jaundice) m dicate serious blood disorders. Frequent C urinalysis with microscopic examination an ommended during sulfonamide therapy.

Precautions: Use cautiously in patients wit paired renal or hepatic function, severe all bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in wh dose-related hemolysis may occur. Maintai adequate fluid intake to prevent crystalluri stone formation.

Adverse Reactions: *Blood dyscrasias* (agra ulocytosis, aplastic anemia, thrombocyto leukopenia, hemolytic anemia, purpura, h thrombinemia and methemoglobinemia); a *reactions* (erythema multiforme, skin erup Stevens-Johnson syndrome, epidermal ne urticaria, serum sickness, pruritus, exfolia dermatitis, anaphylactoid reactions, perior edema, conjunctival and scleral injection, sensitization, arthralgia and allergic myoc *G.I. reactions* (nausea, emesis, abdominal hepatitis, diarrhea, anorexia, pancreatitis stomatitis); *CNS reactions* (headache, per neuritis, mental depression, convulsions, hallucinations, tinnitus, vertigo and insom *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, periart nodosa and L. E. phenomenon). Due to ce chemical similarities with some goitrogens uretics (acetazolamide, thiazides) and oral glycemic agents, sulfonamides have cause instances of goiter production, diuresis an glycemia. Cross-sensitivity with these age exist.

Dosage: Azo Gantanol is intended for the painful phase of urinary tract infections. U *adult dosage:* 2 Gm (4 tabs) initially, then (2 tabs) B.I.D. for up to 3 days. If pain pe causes other than infection should be sou After relief of pain has been obtained, con treatment with Gantanol (sulfamethoxazol be considered.

NOTE: Patients should be told that the or dye (phenazopyridine HCl) will color the u

Supplied: Tablets, red, film-coated, each ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and

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When painful spasm is the presenting symptom...

...in the functional bowel/irritable bowel syndrome*

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10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.

Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis, cycloplegia; increased ocular tension; loss of taste, headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage: Bentyl 10 mg capsule and syrup: *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

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Physicians and other health care professionals now can dial a toll-free telephone number to report problems they've experienced with drugs, medical devices and *in vitro* diagnostic products. The number is 800-638-6725. The Food and Drug Administration encourages health professionals to report: hazardous or potentially hazardous products; product mislabeling or improper labeling; incomplete or confusing instructions; erroneous information; designs that encourage human error; performance failures; non-sterile products; packaging errors; defective components; quality control problems; and any other situation that could affect the safety and efficacy of a product. The FDA uses these problem reports to help it determine when a product poses a significant potential hazard to health, sometimes necessitating a recall. The information also is used to detect recurring or widespread problems and to search out deficiencies useful in developing profiles and trends of manufacturer and/or product problems that might suggest needed amendment of performance or good manufacturing standards. ■

CONTRIBUTIONS CES FOUNDATION AUGUST 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1979.

Unrestricted

John Allen, MD; SMS Members—*Voluntary Contributions*

Restricted

NMC Projects, Inc.—*General Scholarship Fund*

Memorials

Dr-Mrs Robert Schmidt—*George A Merline (Brown County Study Loan Fund)*
Dr-Mrs Stephen Austin—*Neil Branson (Brown County Student Loan Fund)*
Dr-Mrs Loren Hart—*Mrs Fred Sehring (Brown County Student Loan Fund)*
Mr-Mrs Donald Idzik—*Rudolph Bott*
State Medical Society—*Abraham J Levin, MD; Alvin B Zautke Jr, MD; Cyril R MacLean, MD; David M Regan, MD; James E Morgan, MD; Rowland W Leiby Jr, MD; Dean H Jeffers Jr, MD; John C Weber, MD*

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

James Zelinski, MD, Phelps, has joined the medical staff of the Northwoods Living Care Center. Doctor Zelinski graduated from the University of Michigan Medical School, Ann Arbor, completed his internship and residency at Michigan State University affiliate St Mary's Hospital in Grand Rapids. His practice includes general medicine, obstetrics, and surgery.

Dale M Geiss, MD, Milwaukee, recently became affiliated with the medical staff at Milwaukee Children's Hospital in the Department of Thoracic and Cardiovascular Surgery. A 1971 graduate of Baylor College of Medicine, Houston, Tex, Doctor Geiss served his internship at Hennepin County General Hospital in Minneapolis. His residency was completed at Kern Medical Center, Bakersfield, Calif, the University of California, San Diego, and the Medical College of Wisconsin.

Scott S Erickson, MD, Rhinelander, recently joined the Bump Medical Clinic in the Department of Internal Medicine. Doctor Erickson also is sharing the medical coverage of the Forest Memorial Medical Center, the satellite of the Bump Medical Group, in Crandon. He graduated from the College of Medicine in Chicago, and served his internship and residency at the University of Minnesota.

L Bryant Hale, MD, recently opened his medical practice in Hales Corners. He graduated from the Medical College of Wisconsin and served an internship at Milwaukee County General Hospital. He served his residency at the Eye Institute at the Milwaukee County Complex. Doctor Hale is associated with the Eye Institute where he is an assistant clinical professor. He also is on the medical staff of West Allis Memorial Hospital.

Fred Walbrun, MD, recently began his practice at the Tri-County Medical Clinic, Pulaski. Doctor Walbrun graduated from Georgetown University Medical School and served his internship at St Elizabeth Hospital, Boston. Doctor Walbrun is a member of the Public Health Service Corps.

John P Hermann, MD, Sheboygan, recently joined the medical staff of the Sheboygan Clinic. Doctor Hermann graduated from the University of Wisconsin Medical School, Madison, and served his internship at the University of California, San Francisco. His residency training in urology was completed at the University of Wisconsin Hospitals.

Dorothy Wittmann Betlach, MD,* Janesville, recently assumed the presidency of the University of Wisconsin Medical Alumni Association. She is the first woman to be elected president of the association in its 24-year history. Doctor Betlach graduated from the University of Wisconsin Medical School, Madison, in 1946.

Alois F Proett, MD, Chippewa Falls, recently joined the medical staff of St Joseph's Hospital. An orthopedic surgeon, he is associated in practice with MDs Richard D Kennedy and George E Fleming. He graduated from the University of Nebraska Medical School, Omaha, in 1973 and served his internship at Virginia Mason Hospital, Seattle, Wash. His residency was completed at the University of Nebraska Medical Center.

Clyde C Lawnicki, MD,* urologist at the Gundersen Clinic, Ltd-LaCrosse Lutheran Hospital, recently was accepted into the Society for Pediatric Urology. Doctor Lawnicki is the sixth medical specialist in Wisconsin who is a member of the society.

Kenneth H Yuska, MD*, Marinette orthopedic surgeon, is shown above with a patient, Sandy McLean. Doctor Yuska recently spent a week in Haiti doing volunteer work on handicapped children. Operations included those to correct deformities of the feet, heel cord lengthening, leg shortening and club foot procedures and releases on hips and knees. (Photo courtesy of *Marinette Eagle-Star*).

Joel H Block, MD and **Geoffrey Taylor, MD** recently became associated with the Wausau Medical Center. Doctor Block graduated from the University of New York Medical School and completed his internship and residency program in allergy at Sinai Hospital in Baltimore, Md. Doctor Taylor graduated from the University of Manchester, London, England, and came to the United States in 1976 to serve as chief of Laboratory Investigations Branch, Division of Respiratory Disease Studies, National Institute for Occupational Safety and Health Administration in Morgantown, W Va. He also served as professor of medicine at the West Virginia University Medical Center.

Richard Larson, MD, Greenwood, has joined the medical staff of the Greenwood Clinic. Doctor Larson completed his medical degree at the University of Minnesota Medical School. He served his internship at the Health Sciences Center of the University of Manitoba, Canada, and his residency at the University of Virginia.

Gary Jansen, MD, recently became associated with the medical staff of the Greenwood Clinic. He graduated from the University of Wisconsin Medical School and served his internship at Presbyterian Medical Center, Denver, Colo. Prior to joining the staff at the Greenwood Clinic, he spent six years working in the National Health Service Corps at Pagosa Springs, Colo.

Peter L Loes, MD, Rhinelander, recently became associated with the Schiek Clinic, SC. Doctor Loes graduated from the University of Minnesota Medical School and completed his residency in obstetrics-gynecology at the University of Minnesota Hospital in Minneapolis. While in medical school, he received the "Roche Graduation Award" as an outstanding medical student.

Thomas C Norris, MD,* Onalaska, recently returned to the Gundersen Clinic at Onalaska. He graduated from the University of Wisconsin Medical School, Madison, and served his internship at LaCrosse Lutheran Hospital, and was on the staff at the Onalaska Clinic from 1975-1977. He completed his residency in internal medicine at the Gundersen Medical Foundation, Ltd.

John A Campbell, MD, Marshfield, recently became associated with the Marshfield Clinic in the Department of Internal Medicine. A specialist in pulmonary medicine, Doctor Campbell graduated from Rush Medical College, Chicago, and completed his residency training at the University of Illinois Medical Center.

Jim Burrell, MD, recently joined the medical staff of the Sparta Clinic. He graduated from the University of Minnesota Medical School and completed his family practice residency at the University of North Dakota in Minot.

Steven W Birkholz, MD,* Oconomowoc, recently opened his medical office in the practice of orthopedic surgery. Doctor Birkholz graduated from the Medical College of Wisconsin and served his internship at St Luke's Hospital in Denver. His residency was completed at Milwaukee County General Hospital, Wood Veterans Administration Hospital, Milwaukee Children's Hospital, and at The Medical College of Wisconsin.

Vytas K Kerpe, MD, Sheboygan, has opened his medical office in Sheboygan. He graduated from Loyola-Stritch School of Medicine, Maywood, Ill, where he also completed his residency in internal medicine.

William D James, MD,* Dousman, former president of the State Medical Society of Wisconsin, recently received the annual Legion Band Civic Award at the Oconomowoc American Legion Band concert. Doctor James has practiced medicine in Oconomowoc and Dousman since 1937.

Richard E Neils, MD, Watertown, recently opened his medical practice in Watertown. Specializing in dermatology, Doctor Neils graduated from the University of Minnesota Medical School and completed his residency in Rhode Island. The past three years he has been at the Medical College of Wisconsin where he was chief resident in dermatology.

Bharat Pathakjee, MD, Green Bay, recently became associated with the Hittner Clinic, Seymour. A native of India, he graduated from the M S U of Baroda in 1972. He served an internship and residency at Sinai Hospital in Detroit, Mich, and also completed a six-month student medical clerkship at Illinois Central Community Hospital, Chicago. Prior to joining the Clinic, he had been participating in a subspecialty fellowship in cardiology at the University of Louisville, Ky.

Gary L Shepherdson, MD, Burlington, recently became associated with the Burlington Medical Center's satellite clinic in East Troy. He graduated from Autonoma University Medical School in Barcelona, Spain, and completed his Ob-Gyn residency at Milwaukee County General Hospital. Doctor Shepherdson also completed a family practice residency at St Luke's Hospital in Milwaukee. Prior to joining the Clinic, he had been in private practice in Milwaukee.

Edward Zupanc, MD* of The Monroe Clinic recently was appointed clinical associate professor in the Department of Pediatrics of the University of Wisconsin Medical School, Madison. William E Segar, MD, professor and chairman of the Department of Pediatrics at the UW-Madison, said that Doctor Zupanc's promotion is "in recognition of his teaching contributions to our undergraduate educational program." Doctor Zupanc has been a clinical instructor for the Department of Pediatrics since 1957.

H Laurence Burdick, MD,* Milton physician for 32 years recently retired from his medical practice. He graduated from the University of Wisconsin Medical School, Madison, in 1943 and served his internship at Ohio Valley General Hospital, Wheeling, W Va. In 1971, he received the Pillar of Milton Award for outstanding volunteer service to his alma mater and the cause of private, liberal arts education. He was a 1937 graduate of Milton College.

Albino L Settimi, MD,* Elm Grove, recently was named chief of medicine at Deaconess Hospital in Milwaukee. Doctor Settimi, an internist and graduate of the University of Minnesota Medical School, also is director of the Comprehensive Health Evaluation Service (CHES) program at the Masonic Diagnostic and Treatment Center at Deaconess. He has been on the medical staff since 1956.

Ijaz N Qureshi, MD,* Milwaukee, has been appointed chief pathologist and Director of Laboratories at St Luke's Hospital, Milwaukee.

Robert A Narotzky, MD, Eau Claire, recently became associated with the Midelfort Clinic in the Department of Neurological Surgery. Doctor Narotzky graduated from Northwestern University School of Medicine, Evanston, Ill, and completed residency training at the Mayo Clinic in Rochester. He received the 1979 Mayo Graduate School of Medicine Neurosurgical Travel Award.

Tom Anderson, MD, recently was appointed associate professor of medicine at the Medical College of Wisconsin. He also has been named chief of MCW's hematology and oncology section and director of the interdisciplinary oncology unit at Milwaukee County Medical Complex. Before accepting the position at MCW, Doctor Anderson served four years as a senior investigator in the medicine branch, division of cancer treatment, the National Cancer Institute, at the National Institutes of Health. He is a 1969 graduate of Stanford University School of Medicine and served his residency training at Strong Memorial Hospital, Rochester, New York, and fellowship training at NCI.

Paul E Reinholtz, MD, Madison, recently opened his medical practice in Madison. A 1976 graduate from the University of Wisconsin Medical School, Doctor Reinholtz completed his family practice residency at Good Samaritan Hospital, Phoenix, Ariz. He is a member of the American Academy of Family Physicians.

William Clancy, MD,* head of the Department of Sports Medicine at the University of Wisconsin, Madison, will be attending the Winter Olympics at Lake Placid in 1980 as one of the many on-the-scene doctors who will give medical treatment. An orthopedic surgeon, Doctor Clancy graduated from the State University of New York and completed his internship at St Luke's Hospital at Columbia University in New York.

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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand–name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
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Eugene J Nordby, MD* (left) recently was honored with the prestigious Knight's Cross, First Class of the Royal Order of St Olva for his work in keeping alive the Norwegian heritage in America. Byron C Ostby, Consul of Norway (center), and Don Haugen, president of Idun Lodge No 74, Sons of Norway (right), look on as Doctor Nordby admires the medal given to him on behalf of King Olav V of Norway. (Photo courtesy of David Sandell/*The Capital Times)*

Everett Lindsey, MD, Mineral Point, has joined the medical staff of the Dodgeville Clinic. He graduated from Ohio State Medical School in 1973 and completed his residency training in internal medicine and obstetrics at Milwaukee County General Hospital.

Paul F Elbing, MD, Amery, has joined the medical staff consisting of MDs H A Dasler;* F L Whitlark;* W R Bryne, and D J Schroeder* at the Cornwall Clinic. A 1976 graduate of the University of Wisconsin Medical School, Madison, Doctor Elbing completed his family practice residency in Eau Claire and is Board certified.

David Myerowitz, MD, Madison, recently was appointed assistant professor of surgery at the University of Wisconsin Medical School's Division of Thoracic and Cardiovascular Surgery. The announcement was made by Donald Kahn, MD, the division chairman. Doctor Myerowitz came to the UW Medical School and UW Hospital and Clinics from the University of Chicago Hospital where he completed a fellowship in cardiothoracic surgery.

Cole S Northup, MD, Sheboygan, recently became associated with the medical staff of the Sheboygan Clinic. He graduated in 1974 from Northwestern University School of Medicine and completed an internship at Buffalo, New York General Hospital, followed by residency training at the State University of New York in Buffalo. Doctor Northup also served a fellowship at the University of Washington, Department of Orthopedics, in Seattle.

George L Hess, MD, Sheboygan, recently joined the medical staff of St Nicholas Hospital, Sheboygan, as an anesthesiologist. Doctor Hess graduated from the Medical College of Wisconsin and completed his residency at the Medical College of Wisconsin's affiliated hospitals in Milwaukee. Prior to coming to Sheboygan, Doctor Hess participated as a research associate in anesthesiology.

Dennis Henzig, MD, and **Timothy Bowers, MD,*** Wisconsin Rapids, have joined the Riverview Hospital medical staff. Doctor Henzig completed his family practice residency at Mercy-St Luke's Family Practice Program in Davenport, Iowa, and is a graduate of the University of Iowa Medical School. Doctor Bowers graduated from the University of Wisconsin Medical School, Madison, and completed a residency in anesthesiology at the University of California, Davis, Calif. He is director of the Department of Anesthesiology at the hospital.

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MDs Robert Marek, John Hovey, Robert McWhirter, and **Clyde M Chumley II** recently joined the Medical Associates Health Center in Menomonee Falls. Doctor Marek, a dermatologist, graduated from the University of Wisconsin Medical School. Doctor Hovey is an ophthalmologist from San Diego, Calif, where he practiced at the Balboa Naval Hospital. Doctor McWhirter, an orthopedic surgeon, had been practicing at the Naval Regional Medical Center. Doctor Chumley is an obstetrician-gynecologist who had been associated with the Dept of OBG at the University of Missouri Medical Center in Columbia, Mo.

The late John A Schindler, MD was memorialized recently when the New Glarus Clinic, a branch of The Monroe Clinic, held a dedication ceremony during which a portrait of Doctor Schindler was presented to the Clinic. Doctor Schindler was a native of New Glarus and was one of the original founders of The Monroe Clinic. Accepting the portrait on behalf of the Clinic was Leslie Kindschi, MD.*

Duane Browning, MD, Osceola, recently became associated with the medical staff at Simenstad Clinic. Doctor Browning graduated from the University of Minnesota Medical School in 1976 and served his family practice residency in Minot, North Dakota.

Sherman P Vinograd, MD, retired director of Biomedical Research for NASA, has returned to Madison as the medical director of St Mary's Hospital. Doctor Vinograd had practiced medicine in Madison from 1953-1961 when he received an appointment with the National Aeronautics and Space Administration to become a space doctor.

Gastone G Celesia, MD, Madison, has been named chief of Neurology Service at the William S Middleton Memorial Veterans Hospital, Madison. A graduate from the University of Genoa Medical School, Genoa, Italy, Doctor Celesia previously served as vice-chairman and professor of neurology at St Louis University, St Louis, Mo.

Thomas L Holbrook, MD,* Waukesha psychiatrist, recently was appointed medical director of hospice services of Rogers Memorial Hospital, Oconomowoc. Doctor Holbrook succeeds Robert H Sewell, MD,* who has served as medical director since the hospice opened in January 1978. Doctor Holbrook is on the medical staff of Oconomowoc Memorial, Waukesha Memorial, and Elmbrook Memorial hospitals. He participated in planning and organizing the hospice, and has been on the medical staff of Rogers Memorial Hospital for several years.

Paul M Grossberg, MD recently became associated with the Doctor's Park Family Physicians in Platteville. A pediatrician, Doctor Grossberg graduated from the State University of New York, Upstate Medical Center in Syracuse, and completed his residency training at the University of Wisconsin Hospitals, Madison. For the past year, he has served as director of the Student Health Service at UW-Platteville and will continue working on campus for the 1979-80 school year.

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Herbert Berkoff, MD* and **Fredric Jarrett, MD,** Madison, physicians at the University of Wisconsin Medical School and UW Hospital and Clinics, recently were elected to membership in the International Cardiovascular Society. Doctor Berkoff graduated from New York University Medical Center in 1964 and joined the UW Medical School faculty in 1972. Doctor Jarrett graduated from Harvard University Medical School in 1967 and joined the UW Medical School faculty in 1975.

William C Boake, MD, Madison, American College of Cardiology Governor for the State of Wisconsin, recently announced that the following cardiovascular specialists have achieved the ACC's membership rank of fellowship. They are MDs William O Myers,* Marshfield; Gerard T Parent,* Wauwatosa; and Richard T Shore,* Milwaukee.

Guillermo Ramirez, MD, Madison, professor of Human Oncology, recently was awarded an Honorary Academic Degree from the Pontificia Universidad Catolica De Chile (Pontifical Catholic University of Chile). The award was given in recognition of his work in the cancer field and his interest in the advancement of the Latin American scientific community.

Robert L Gilbert, MD,* LaCrosse internist and University of Wisconsin Medical School preceptor, recently received the institution's prestigious annual Max Fox Preceptor Award. The award was presented by UW Medical School Dean Arnold L Brown, MD, at a meeting of the LaCrosse County Medical Society in LaCrosse. Doctor Gilbert, a 1941 graduate of Yale University Medical School, has served as a UW Medical School preceptor for the past 21 years.

Christopher L Larson, MD,* Sheboygan, recently opened his medical practice in ophthalmology. A 1975 graduate from the University of Wisconsin Medical School, Doctor Larson served his internship at Presbyterian Medical Center, Denver, Colo, and his residency in ophthalmology at the University of Wisconsin hospitals. He also is on the staff at the University of Wisconsin, Madison, in the Department of Ophthalmology.

John Renner, MD,* professor and former chairman of the Department of Family Medicine and Practice at the University of Wisconsin Medical School, Madison, has been named Special Assistant Dean for Physician Retention and Distribution at the UW Medical School. As Special Assistant Dean, Doctor Renner will assist the Medical School to identify factors which influence physician practice location and develop programs to meet the state's manpower needs. Doctor Renner will retain his position as professor in the Department of Family Medicine and Practice and will continue to work there on a part-time basis.

Richard Holden, MD* and **Bruce Cochrane, MD,** Watertown, recently joined the medical staff of Watertown Family Practice. Doctor Holden graduated from the University of Missouri School of Medicine and completed his family practice residency at St Mary's Hospital in Madison. Doctor Cochrane is a 1976 graduate of Chicago Medical School and completed his residency at Southern Illinois University School of Medicine in Springfield. They have joined Terry Turke, MD,* and Fred Gremmels, DO,* in the practice.

Alan Detwiler, MD, Fort Atkinson, recently began his medical practice in association with the Fort Atkinson Memorial Hospital. A specialist in internal medicine, Doctor Detwiler is a graduate of the University of Illinois College of Medicine and completed his residency training at the Medical College of Wisconsin affiliated hospitals in Milwaukee.

Steven Birkholz, MD,* Oconomowoc, recently was named to the medical staff at Memorial Hospital. A graduate from the Medical College of Wisconsin, Milwaukee, Doctor Birkholz completed an internship at St Luke's Hospital in Denver, and his residency with the Medical College of Wisconsin.

Jorge Valcarcel, MD, Merrill, recently became associated with Merrill Medical Associates SC. Doctor Valcarcel graduated from the Cayetano Hereda University, Lima, Peru, and served his residency at St Luke's Hospital, St Louis, Mo, and Drake Memorial Hospital, Cincinnati. He is on the medical staff of Holy Cross Hospital in Merrill.

Peter Melcher, MD, Woodruff, has joined the medical staff of Lakeland Medical Associates in the Department of Orthopedic Surgery. A graduate of New Jersey College of Medicine, he served his residency at the University of Washington in Seattle.

George H Roenning, MD, Sturgeon Bay, recently became associated with MDs John J Beck* and Edward McAuliffe in family practice at the Door County Medical Center. He graduated from Rutgers Medical School in Rutgers, NJ, and completed his internship and residency at St Mary's Hospital, Madison.

James J Beier, MD, Mosinee, recently joined the medical staff of Mosinee Clinic in the Department of Family Practice. A Chicago native, he graduated from the University of Illinois Medical School and completed his internship at the University of Illinois affiliated hospitals. He completed his residency in family practice as a Naval medical officer assigned to Camp Pendleton, Calif, subsequently serving on the medical staff of the Naval Regional Medical Center.

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News Highlights

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

American Academy of Family Physicians, at its 31st Annual Scientific Assembly held in Kansas City, Mo, elected the following Wisconsin physicians as fellows of the Academy. The MDs are as follows: C S Azcueta,* Max O Bachhuber,* Dragan Bogunovic,* Mahendr S Kochar,* Milwaukee; Mark E Boyken,* St Croix Falls; Jaime D Cabatingan,* Thomas J Shewczyk, Cedarburg; Richard O Haight,* Appleton; Robert G Hansel,* John T Siebert,* Baraboo; Carl J Saggio,* Fond du Lac; Richard H Siedenburg,* Jefferson; James J Tydrich,* Richland Center; Thomas Wex,* West Bend; and Douglas D Wilson,* Salem, Ohio, (formerly Watertown). The meeting held in Atlanta, Ga, on October 8-11, had as its theme, "A Special Decade, 1969-1979," noting the 10 years family practice has been a recognized medical specialty.

Milwaukee Psychiatric Hospital's president, Gerald E Schley, recently announced the appointment of Richard Kirsch as program director of Dewey Center, a facility for treatment of patients suffering from alcoholism and other drug abuse. Mr Kirsch joined the staff of Dewey Center after serving for the past four years as coordinator of alcohol and drug abuse services for the Waukesha County Unified Services Board. He previously held counseling positions in alcohol and drug abuse programs in the Milwaukee area and served with the Veterans Administration hospitals at Wood, Wis, and Minneapolis, Minn.

Wisconsin Health Care Review, Inc has moved its offices from the SMS headquarters building in Madison to: Olde Towne Office Park, 6417 Odana Road, Suite A, Madison, Wis 53719 (608/273-2208).

Paul Simms, Madison, former director of the SMS Physicians Alliance Division, has been named executive program director for the Wisconsin Medical Assistance Program administered by EDS Federal Corp. Mr Simms succeeds Jose' Ofman who has been reassigned to Dallas, Texas, to serve as national manager of planning and support systems.

John P Hein, Milwaukee, has been installed president of the Health Care Public Relations Society/Southeastern Wisconsin. Mr Hein is information director for Milwaukee County Medical Complex and is a member of the Public Relations Society of America. He is a veteran of 42 years in the public relations field, all but three in the areas of health, welfare, education, or church-related services.

Secretary-treasurer of HCPRS is Ms Opal Iverson, Muskego, administrative assistant for the Blood Center of Southeastern Wisconsin. Gary Buerstatte, Waukesha Memorial Hospital, has been named program chairman. Kenneth A Vetrovec, St Mary's Medical Center, Racine, was named to head the "Front-Line" seminar, an annual HCPRS function to improve communication skills of healthcare facility employes, including clerks, cooks, and housekeepers.

The HCPRS, Mr Hein explained, is an affiliate of the American Society for Hospital Public Relations. Its aims are to increase the professionalism of healthcare communicators throughout Southeastern Wisconsin, and to improve public understanding of services provided by their healthcare facilities.

Veterans Administration medical center at Wood has been named a participant in VA's revamped Spinal Cord Injury Fellowship Program. VA chief Max Cleland said two physicians will be awarded fellowships and will begin an intensive two-year course of training at the Wood VAMC in July 1980. The program provides a unique, multi-disciplinary approach to the treatment of patients and involves urology, plastic surgery and neurosurgery, orthopedics, internal medicine, rehabilitation and psychiatric services, Cleland said.

"The Wood VA Medical Center was selected," Cleland said, "because of its excellent spinal cord injury service, its relationship with the other departments within the hospital, and because of the fine support given by the University of Wisconsin Medical School."

Burton A Wagner, Madison, has been appointed administrator of the State Division of Community Services. He succeeds Leonard Ganser, MD,* Madison who resigned last June.

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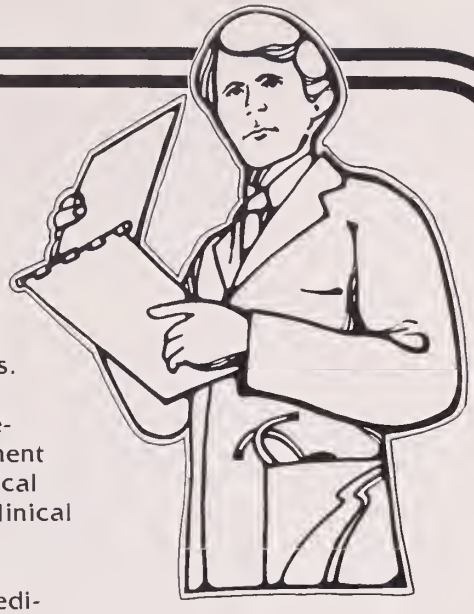

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PHYSICIAN SURVEY

Characteristics of Wisconsin physicians (MDs and DOs), such as specialty, locations, age, education practice, have been the subject of a series of surveys by the Bureau of Health Statistics in the State Division of Health. The surveys, begun in 1975, are conducted by means of an attachment to the license renewal notice.

The most recent survey of Wisconsin physicians was completed following the 1978 license renewal cycle. Renewal notices for 1980-81 will be mailed in November to all physicians licensed to practice in Wisconsin. The State Medical Society joins with the Bureau in urging physicians to fully answer the survey so that future decisions affecting the supply and distribution of services will be supported by accurate information.

Aggregate data from these surveys is available to any public or private agency or person; the confidentiality of individual respondents is fully protected, the Bureau states. Response has been over ninety percent on the most recent surveys. Information which is public record, such as current mailing address and specialty, is obtained from the State Medical Examining Board for those physicians who choose not to respond to the survey form. Fixed information, such as birthdate and year and place of graduation from medical school, is maintained on a permanent file to save on survey costs and respondent time and effort.

The survey data allows a complete count of all licensed physicians, although it may be subject to error, particularly for small areas, due to changes occurring after the survey date, or missing data on the practice characteristics of physicians who do not respond. Also, physicians practicing entirely in federal facilities such as VA hospitals are not necessarily included as they are not required to hold a Wisconsin license. Whether these data present an accurate picture of services available in a given area or to specific populations will be a consideration of the Committee on Physician Distribution.

Data from the surveys has been used in deliberations of various state bodies such as the Health Policy Council, the Medical Education Review Committee, and the committees of the Wisconsin Legislature. The data is also used by health planners at the local (Health Systems Agency—HSA) level and by state and federal offices in determining areas of physician shortage under regulations governing loan forgiveness and National Health Service Corps placement. ■

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Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

8-3305 (Y371A)

Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease . . . consider Quinamm . . . simple, convenient dosage—usually just one tablet at bedtime . . . can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

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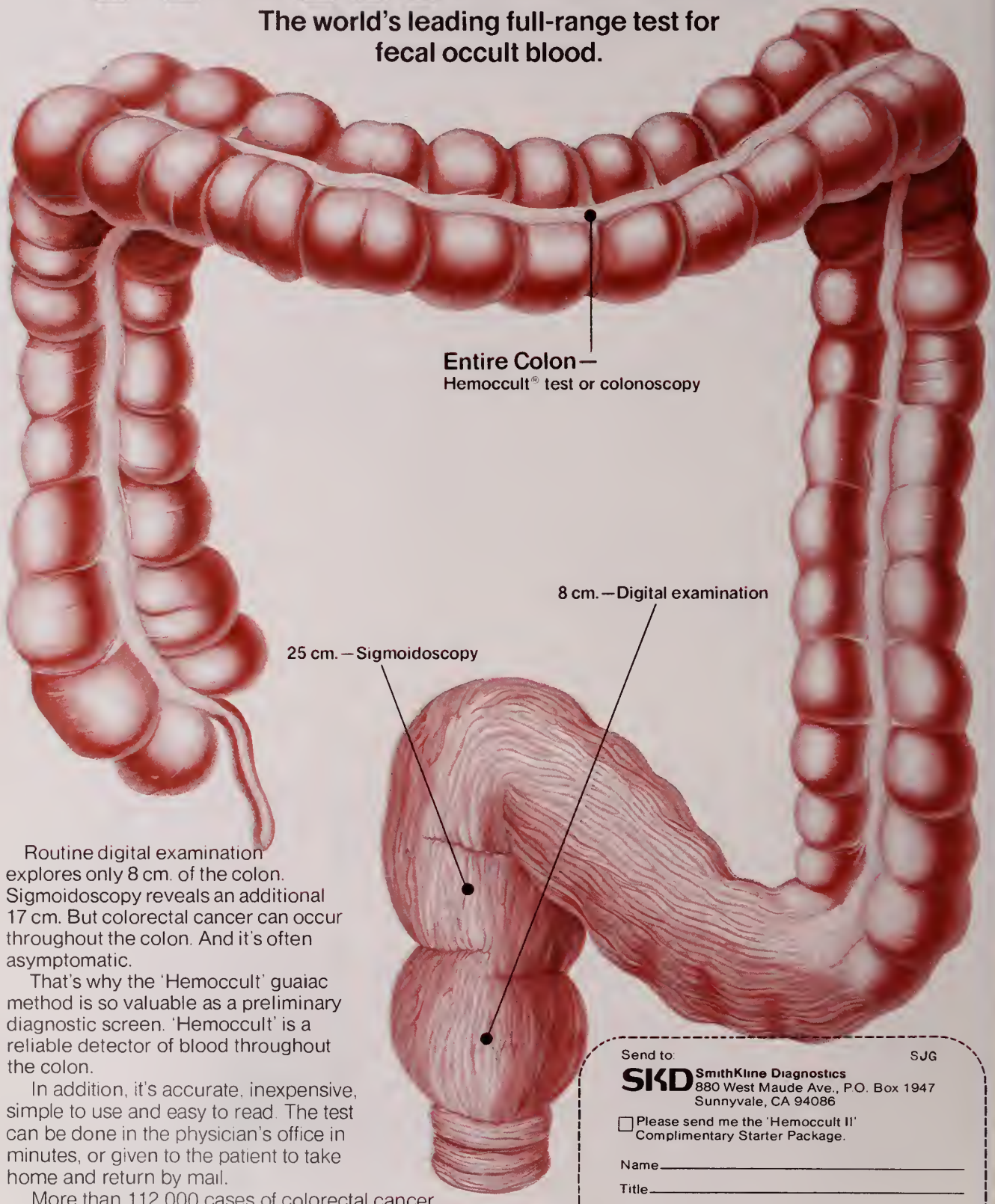
The world's leading full-range test for fecal occult blood.



Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the 'Hemoccult' guaiac method is so valuable as a preliminary diagnostic screen. 'Hemoccult' is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in the physician's office in minutes, or given to the patient to take home and return by mail.

More than 112,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment.

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Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 30¢ per word, with a minimum charge of $12.00 per ad. BOXED AD RATES: $15.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

Physicians Exchange

PHYSICIAN(S) INTERESTED IN family practice to locate in Baldwin, Wis. Excellent hospital facilities located adjacent to Clinic. Offers excellent family environment and a variety of recreational activities. 40 minutes east of St Paul, Minn. Contact Gordon Palmer. Admin, Baldwin Community Hospital, Baldwin, Wis 54002. Tel: collect 715/684-3311. 10-12/79

GONZALEZ MEDICAL CENTER is seeking a pediatrician who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, telephone 414/344-1120; 414/671-5410; 414/476-8624. 8-12/79, 1/80

THE WAUSAU MEDICAL CENter, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Dermatology
- Orthopedics
- Otolaryngology
- Radiology (2)

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, wirte John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 8tfn/79

WANTED — VOLUNTEER PHYsician to work at free VD clinic on Milwaukee's lower eastside with primarily a gay clientle. Six hours per month. Contact: Medical Director, VD Clinic, Farwell Center, 1568 North Farwell, Milwaukee, Wis 53202. 10-11/79

OB-GYN: IMMEDIATE OPENing with 8-man, multispecialty group. To join present Ob-Gyn, four internists, two pediatricians, and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing—pension plan. Young group. Contact James L Algiers, MD or Clinic Manager, Parkview Medical Associates, Ltd, 1004 East Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/79

MULTISPECIALTY GROUP OF 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Dermatologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

MILWAUKEE HMO—2 FAMILY physicians needed for innovative group practice. New multi-million dollar facility with full support services located in the suburb of Greenfield. Present staff includes four family practitioners, a physician's assistant and a nurse practitioner. Congenial atmosphere, four day week, light call. Attractive salary and fringe benefits. Contact Philip Eckstrom, MD, Family Health Plan, 6901 W Edgerton Ave, Milwaukee, Wis 53220. Tel: 414/421-8400. 9-11/79

WANTED: PHYSICIAN TO JOIN group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Marie Olson, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

PHYSICIANS—WE SAVE YOU TIME AND KEEP YOUR SEARCH COMPLETELY CONFIDENTIAL

We're medical professionals ourselves so we recognize outstanding opportunities. Tell us your geographic and position choices and salary expectations. We'll match them with the career opportunities we have available in Wisconsin as well as nationwide. No charge to applicants.

Contact Adeline Horner, RN

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Tel: 608/222-1616
Licensed Employment Agency

1tfn/79

Physicians Exchange

continued

WANTED: FAMILY PRACTICE physician to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

FAMILY OR GENERAL PRACtitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

GENERAL INTERNIST WITH GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info: J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

FAMILY PRACTITIONERS OR internist and pediatrician for satellite primary care office located in West Allis, Wis. Call shared by other members of 34-physician multispecialty group. For further information contact E Daun, Administrator, Northpoint Medical Group, 2388 N Lake Dr, Milwaukee, Wis 53211. Tel: 414/289-3918. 4tfn/79

WANTED: ORTHOPEDIC SURgeon to practice with one other orthopedic surgeon, multispecialty clinic, primary care oriented with 13 MDs. New hospital immediately adjacent to clinic. 65 miles from Minneapolis/St Paul on I-94. Ideal situation for family-oriented lifestyle. Recreation, time off, congenial group. Rapidly growing college community. No seniority and full status after one year. Competitive salary first year. Contact Rex Shaffer, Manager, or Dr James Haemmerle. Call collect 715/235-9671, or write Red Cedar Clinic, 2211 Stout Road, Menomonie, Wis 54751. 7-12/79

FAMILY PHYSICIAN: APPLEton, Wis, to join four certified ABFP physicians. City of 60,000—economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact: K E Buchanan, MD, 620 E Longview, Appleton, Wis 54911. Tel: 414/734-7144. 9-11/79

WANTED: GENERAL PRACTItioner to join well established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Rose-Jensen-Manabat, 621 E Walnut St, Green Bay, Wis 54301. Tel: 414/437-4366. 10-12/79

WANTED: OSHKOSH, WIS. CAreer Emergency Physician, fulltime. Experienced, residency training preferred. ACEP. New ED facilities. Paramedic program. 45-hour week, competitive salary, generous fringes including malpractice, corporate paid retirement plan, CME allowance. Send CV to Thomas Loescher, MD, 2520 Crestview Drive, Appleton, Wis 54911. 10-11/79

OB-GYN SPECIALISTS DESIRED. Enjoy the security of group practice with the freedom of independent practice. If you are Board certified or Board eligible in OB-GYN, we have an interesting opportunity for you. One or two specialists are needed immediately to form an independent OB-GYN practice in a very desirable Northern Wisconsin community with a drawing population of 65,000. Active practice assured. All major specialists available for consultation. Business advice, technical and legal, will be provided. Outstanding personal benefit programs available. Income potential great. Generous starting income guaranteed. A 35 million dollar hospital just opened with available office space. For further information call 715/842-3202, or write Mr Lloyd Engstrom, PO Box 1646, Wausau, Wis 54401. 10tfn/79

PSYCHIATRIST—MEDICAL DIrector for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

ALGOMA CLINIC NEEDS ANother doctor. Please contact J F March, MD, 413 Fourth St, Algoma, Wis 54201. 10tfn/79

FIFTY PHYSICIAN MULTIspecialty clinic in western Wisconsin wants family practitioner to work in nearby satellite offices. Excellent cultural, educational and recreational facilities. 90 miles from Minneapolis. Please contact G E Owen, MD, Midelfort Clinic, Ltd, 733 W Claiemont Ave, Eau Claire, Wis 54701 or call 715/839-5222. 7-10/79

MILWAUKEE, WISCONSIN Emergency Department Physician—Ground floor opportunity for Emergency Department Practice at modern 300-bed teaching hospital; flexible rotating scheduling; excellent remuneration; paid professional liability insurance; Emergency Department experience preferred or postgraduate training. Send CV to Dept 468 in care of the Journal or call toll-free 1-800-325-3982 for details. 7tfn/79

RADIOLOGIST — BOARD CERtified is needed to become the fifth associate in an active radiology practice. One or two years experience desirable. Call 715/842-0624, or write W Mahony, MD, Radiology Associates of Wausau, SC, 425 Pine Ridge Blvd, Wausau, Wis 54401. 6tfn/79

FAMILY OR GENERAL PRACtitioner: One or more to serve the City of Sheboygan Falls. Office space available. Hospitals within 5 miles. Great opportunity, over 5,000 people in progressive community without a full time physician. Write to: Sheboygan Falls Chamber of Commerce, PO Box 1, Sheboygan Falls, Wis 53085. p9-10/79

BOARD CERTIFIED OR ELIGIble primary care internists and family practitioners wanted for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel:414/289-5910. 9-12/79

WANTED: GENERAL SURgeon, orthopedic surgeon, urologist, and ENT physician to join a group of nine family practitioners, one general internist in a rural community in northeastern Wisconsin. For additional information, contact Lloyd Cotts, MD, Rice Lake, Wis. Tel: 715/234-9031. 8-10/79

PRIMARY CARE PHYSICIAN needed to join established and expanding semi-rural primary care center located within 20 miles of Madison, Wisconsin. Two additional PRIMARY CARE PHYSICIANS needed by summer 1980 for newly developing center also located within easy drive of Madison. A professional advisory group, Health Care Associates, provides management and support services with emphasis on problem-oriented system. Minimum compensation guarantee and opportunity to purchase practice within two to five years. Send curriculum vitae to J M Nelson, MD, 202 South Park St, Madison, Wis 53715. Tel: 608/267-6320. 8-10/79

FAMILY PRACTITIONER wanted for rural area in NW Wisconsin, town of 2500, service area includes 25,000 patients. Joint four ABFP and one Board certified surgeon in a growing family oriented group practice. Excellent salary and benefits. New large clinic building ready for occupancy June 1, 1980, close to JCAH approved hospital. The service area is one of the most desirable living areas in Wisconsin with unlimited outdoor recreation available. Contact: Paul G Goellner, MD, Spooner Clinic Ltd, Spooner, Wis 54801. Tel: 715/635-2151. 10-12/79, 1/80

FAMILY PRACTICE — SOUTHeast. Private practice opportunity group or solo in medium-size city with new 150-bed hospital. Present medical staff of 24 with three FPs age 64. Attractive office space and complete financial assistance package. Family oriented stable community. Curriculum vitae in confidence to: Mr William Anderson, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Ga 30338. p10-12/79

FAMILY PRACTITIONERS. Good opportunity for one or two family practice physicians to join a well established three-man clinic (includes surgeon). Present staff leases modern, up-to-date, ten-year old clinic from city. Unlimited potential in a setting suited for aggressive, progressive physicians like yourself. JCAH hospital physically attached to 175-bed nursing facility. Receiving consultant specialty visitation services via the University of Minnesota in areas of Otolaryngology, Pulmonary Medicine, Neurology, Cardiology, Urology, and Internal Medicine. Located in heart of state's finest goose hunting area, fishing and lake cabin life a stone's throw away. Good schools; quiet community, with slow pace of living that includes our own cultural affairs building for staging local drama and musical activities. Are you interested enough to find out more about us? If so, contact Mr Richard L Range, Admin, Madison Hospital Association, 820 Third Ave, PO Box 184, Madison, Minnesota 56256, or call collect 612/598-7556 (office) or 612/598-7974 (home). 9-11/79

PEDIATRICIAN TO JOIN 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend. Wis 53095. 9tfn/79

CAREER ORIENTED ER PHYsician needed immediately in southeastern Wisconsin city of 80,000 on Lake Michigan between Chicago and Milwaukee. Multispecialty backup. Excellent nursing staff. Starting salary in excess of $70,000 per year based on 42-hour week. Send CV to Emergency Room Associates, 7743 Third Ave, Kenosha, Wis 53140. 8-10/79

GROUP HEALTH COOPERAtive of south Central Wisconsin. A growing federally qualified staff model HMO—is recruiting family practitioners for January 1980. Excellent salary, pension and benefit program in an area of natural beauty make living and working here very attractive. Write or call David S Grab, MD, Medical Director, 1 South Park St, Madison, Wis. Phone 608/257-9700. An Equal Opportunity Employer. 7-12/79

RACINE MEDICAL CLINIC, SC, multispecialty group of 18 physicians has a practice association for

- Internist
- Obstetrician-Gynecologist
- Family/General Practitioner

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 7tfn/79

INTERNIST—THIS IS A FINE opportunity to join a five-man, well established, internal medicine group with both downtown Milwaukee and suburban offices for someone either in solo practice or completing residency. Excellent starting salary, fringe benefits, hospital associations, and teaching appointments. Please send curriculum vitae to Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 8-11/79

FAMILY PRACTICE, ENT AND Internal Medicine positions available with a 15-man multispecialty group corporate practice. Modern clinic facility in northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 8-11/79

WISCONSIN — FAMILY PRACtice physician wanted, incorporated clinic group of five, including Family Practice and General Surgery. Ideal town in northern Wisconsin, 35 miles from Minneapolis. Income guaranteed first year. Contact J Craig, New Richmond Clinic, SC, New Richmond, Wis 54017 (715)/246-6911). 7-11/79

RADIOLOGIST: POSITION AVAILABLE

7/1/80 for Board eligible or certified physician to join active radiology practice with group of four in private office and two general hospitals. Contact R E Zellmer, MD, 2500 N Mayfair Rd, Suite 201-203, Milwaukee, Wis 53226. Tel: 414/476-4242. 10-11/79

FAMILY PRACTITIONER TO join three man group. Central Wisconsin community of 10,000 with drawing area of 20,000. Hundred bed accredited hospital. Handsome salary first year with many fringe benefits, full partnership second year. Send curriculum vitae to Merrill Medical Associates, SC, 716 East Second St, Merrill, Wis 54452. Tel: 715/536-2463. 10-12/79

NEUROLOGIST WANTED — Clinical Neurologist wanted to practice in conjunction with a 6-member Internal Medicine Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 470 in care of the Journal. 9tfn/79

FIFTY-MAN MULTISPECIALTY group has an immediate opening for:

- Orthopedic Surgeon
- Ophthalmologist
- Family Practice
- Psychiatrist

Excellent starting salaries with all fringe benefits. Monroe is a very stable economically-strong community of 10,000 located 45 minutes from Madison and 90 minutes from Milwaukee. If interested, please contact T E Peters, MD, The Monroe Clinic, Monroe, Wis 53566. 9-12/79, 1-2/80

THE MIDELFORT CLINIC IS seeking associates in the following areas:

- Family Practice
- Cardiology
- Allergy

This is an opportunity to affiliate with a 48 member group located in a college community of 50,000. Satellite practice locations also available. Contact G E Owen, MD, Midelfort Clinic, Ltd, Eau Claire, Wis 54701 or call 715/839-5222. 10-12/79

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
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Licensed Employment Agency

9tfn/79

Physicians Exchange

continued

OB-GYN WANTED — TO PRACtice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

OPHTHALMOLOGIST RETIRing. Wants to sell building and practice. Excellent real estate investment. In practice 31 years. 95% collection rate. Located Jacksonville, Florida, Gateway city to Florida, and its largest! Call 904/398-0354 after 8:30 pm. 10/79

THE BELOIT CLINIC, A GROWing 28 physician multispecialty group, in cooperation with the Village of Clinton, Wisconsin, will be establishing a satellite facility. Two Board Certified/Board Eligible family practitioners are invited to share in the organization of this challenging project in this desirable location. Very competitive income and membership in the Beloit Clinic, and privileges in Beloit Memorial Hospital would allow the practice of primary care with the advantages of group practice. For further details write Ken Gold, MD, 1905 Huebbe Parkway, Beloit, Wis 53511. 10-11/79

Medical Facilities

SPACE AVAILABLE IN NEW professional building located 25 miles from Milwaukee in Delafield. Only 10 minutes from Oconomowoc hospital and 15 minutes from Waukesha hospital. Easy access to I-94. Design your own floor plan on the ground level. Call 414/276-0431 or 414/392-9401. 9/79

FOND DU LAC FACILITY. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOR SALE — TWO PHYSIOtherapy adult examining tables. Upholstered, brown vinyl cover, paper dispensers, pillows, walnut. No scratches or blemishes — mint condition. List at $225 each, asking $100 each. Tel: 414/278-3621. 10-11/79

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

MEDICAL SUITE AVAILABLE, first floor, 1200 sq ft including reception area, 3 examining rooms, consultation room, lab, 2 bathrooms. Adjacent to Villard Pharmacy, 54th and Villard, Milwaukee, Wis 53218. Phone 414/461-2155 or 414/352-0135. 8-9/79*

FOR SALE: PHYSICIANS EXAM table. Excellent condition. $250.00. Call: 414/494-5231 or write to: San Luis Manor, Attn: Mrs Vi Van Rooy, 2305 San Luis Place, Green Bay, Wis 54304. 9/79

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PERSONALITY DISORDERS: A TREATMENT APPROACH

Friday, November 9 / La Crosse, Wisconsin
presented by Gundersen Medical Foundation Ltd
and La Crosse Lutheran Hospital Foundation Inc
Heritage Club at Rasmus Center, La Crosse Lutheran Hospital

8:30—Registration 9:00—Welcome: David Prindle, ACSW, Assistant Clinical Director, La Crosse Lutheran Hospital Psychiatric Center

9:15—"Personality Disorders: An Overview"
Hans P Anderson, MD. A discussion on diagnostic considerations and various etiologic theories and conceptualizations in an attempt to clarify what clients are considered personality disorders.

10:45—"Inpatient Treatment of Personality Disorders"
Eric Milliner, MD. Following areas to be presented: criterion for inpatient treatment, manipulation issues in therapy, different treatment modalities and rationals; in addition, he will define and explore borderline personality organization.

11:45—Lunch

1:30—"Outpatient Therapy of Personality Disorders"
Clifford J Simske, MD. Delineation of types of outpatient therapies and further consideration surrounding manipulation versus motivation regarding borderline personality organization.

3:00—"Treating Patients with Personality Disorders in General Medical Practice"
James W Terman, MD. Management issues when dealing with personality disorders in general medical practice. Specific emphasis will be placed on hysterical personality disorders.

4:00—Panel discussion and questions from participants with all physicians included. *Moderator: David Prindle, ACSW*

5:00—Adjourn

Registration fee: $25. Gundersen Medical Foundation Ltd accredited: 5 credit hours in Category I of PRA-AMA; 5 elective hours by AAFP.

Info: Medical Education Office, Gundersen Clinic, Ltd, 1836 South Avenue, La Crosse, Wisconsin 54601.

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1979 Wisconsin

Nov 9: *Fall Pediatric Day: Adolescent Medicine Today*, at Wisconsin Center in Madison. Lectures, discussions, workshops, and psychodrama. For pediatricians, family practitioners, internists, psychiatrists, and others interested in this topic. Presented by University of Wisconsin-Extension, Department of Continuing Medical Education and UW-Madison, School of Medicine, Department of Pediatrics. Fee: $45. AMA Category I—7 hours. AAP credit applied for. Further info: Sarah Z Aslakson, CME, 465B WARF Building, 610 Walnut St, Madison, Wis 53706.

Nov 8-9: *Medical Applications of Hormone Immunoassay*, at University of Wisconsin-Madison, Clinical Science Center, Madison. Lectures, discussion, tours, demonstrations. For internists, endocrinologists, pediatricians, technicians, and others with interest in program. Presented by University of Wisconsin-Extension, Department of CME and the University of Wisconsin-Madison, School of Medicine, Department of Physiological Chemistry. Fee: $100. Accredited for 13 hours of AMA Category I credit. Further info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

Nov 9: 18th Annual *Medical-Legal-Industrial Symposium: Cancer and Industry*, Pfister Hotel, Milwaukee. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee 53201. Tel: 414/289-8200.

Nov 9-10: *New Directions for Health Care in Correctional Institutions*. AMA's Third National Conference on Medical Care and Health Services in Correctional Institutions, in cooperation with the American Correctional Health Services Association. At the Radisson Chicago Hotel in Chicago, Illinois. For physicians this CME activity meets the criteria for 14 credit hours in Category I of PRA-AMA. Education objectives are: (1) Orientation of physicians to the field of criminal justice health care. (2) Organization and administration of health care programs in the criminal justice field, including the effecting of appropriate system changes; and (3) Acquaintance of conferees with techniques for implementation of health care service systems. Registration fee: $60. Info: AMA Correctional Program, AMA, 535 N Dearborn St, Chicago, Ill 60610.

Nov 10: Annual Meeting of Wisconsin Society of Pathologists and SMS Section on Pathology, UW Clinical Sciences Center, Madison. Main Auditorium, G5/119. Further details appear elsewhere in this section.

Nov 14: One-Day Seminar for Family Physicians, St Vincent Hospital, Green Bay.

Dec 3-4: Review course for American College of Physicians' Medical Knowledge Self-Assessment Program V (MKSAP V), at The Abbey on Lake Geneva, Fontana, Wisconsin. This Milwaukee course (No A07) deals with allergy and immunology, endocrinology and metabolism, oncology. Physicians who attend it can earn 12 credit hours in Category I of PRA-AMA. Course codirectors are: Charles L Junkerman, MD, FACP, Governor for Wisconsin (ACP), professor of medicine, Medical College of Wisconsin, Milwaukee, and David Graham, MD, FACP, professor of medicine, MCW, Milwaukee. Additional information about MKSAP V courses is available from the ACP, 4200 Pine St, Philadelphia, Pa 19104 (215/243-1200).

Dec 5: *Sexuality and the Older Citizen*, at University of Wisconsin-Green Bay, Community Science Building. For healthcare professionals working in the healthcare field, with emphasis on the older citizen. Fee: $40. Presented by University of Wisconsin-Extension, Departments of Continuing Medical Education, Continuing Education in Nursing, and Extension Services in Pharmacy; and University of Wisconsin-Madison, School of Medicine.

1980 Wisconsin

Jan 3-9: 13th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics and Endocrinology*, at Pfister Hotel and Tower in Milwaukee. Six-day course extended to include a complete up-to-date review of endocrinology and cytogenetics in addition to a thorough resume of gynecological pathology. Designed primarily as a postgraduate refresher course for residents, practitioners, and specialists desiring a current review of the pathology and the reproductive tract. Guest faculty: H W Jones, MD; Georgeanna S Jones, MD; J D Woodruff, MD; and Conrad Julian, MD. Space limitation requires registration for the entire course which is limited to 150 registrants. Approved for 55 cognate hours of prescribed credit by ACOG and meets criteria for 43 hours of credit in Category 1 for the PRA-AMA. A $450 enrollment fee will include 68 selected 35mm slides. Registration fee is nonrefundable. Info: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, Medical College of Wisconsin, 8700 West Wisconsin Ave. Milwaukee, Wis 53226; phone 414/257-8200.

1980 Wisconsin

continued

Mar 1-8: 15th Annual Clinical Conference, sponsored by the Medical College of Wisconsin and the Marquette-MCW Medical Alumni Association, Wailea Beach Hotel, Maui, Hawaii. Info: Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226 (414/257-8204).

Apr 17-18: *Third Annual St Mary's Symposium on Burns and Critical Care.* Presented by St Mary's Hospital Burn Center, Milwaukee. Format: Combination of didactic lectures and workshops, separate and combined sessions for nurses and physicians. Co-chairmen: Burton A Waisbren, MD and George E Collentine, MD. Info: St Mary's Burn Symposium, 2323 N Lake Drive, Milwaukee, Wis 53211.

1979 Others

Nov 7-11: American Medical Women's Association, Albuquerque Hilton, Albuquerque, NM. Info: L Loesel, 1740 Broadway, New York, NY 10019.

Nov 8-10: *Accent on Youth*—a program to familiarize the practicing physician with new frontiers of medicine in pediatrics, at the Hilton Inn in Albuquerque, New Mexico (6 hours Category 1, CME credit). Info: American Medical Women's Association, Inc, 1740 Broadway, New York, New York 10019; phone 212/586-8683.

Nov 15-18: Medical Association of Georgia Scientific Assembly, Omni International Hotel, Atlanta. Registration fee: $50 nonmembers. Info: MAG Scientific Assembly, 938 Peachtree St NE, Atlanta, Ga 30309.

Nov 19-23: Advanced Concepts in Diagnostic Imaging, sponsored by General Electric Company's Medical Systems Division, at the Maui Surf Hotel, Maui, Hawaii. Course is specifically designed for healthcare professionals; it will provide a concentrated presentation of advanced concepts in computed tomography, ultrasound, radiology, and nuclear medicine. Topics to be emphasized include quantitative and qualitative applications of factors enhancing diagnostic accuracy and cost containment in diagnostic imaging. For registration information, contact Charles H Rose, director of Medical Education, PO Box 414 (TI-40), Milwaukee, Wis 53201.

Nov 28-Dec 2: American Medical Tennis Association, Smoke Tree Ranch, Palm Springs, Calif. Info: Bill Drake, Executive Director, PO Box 183, Alton, Ill 62002.

Twenty-third Meeting of the WISCONSIN NEUROLOGICAL SOCIETY
Friday-Saturday, October 26-27, Heidel House, Green Lake

Meetings of the Wisconsin Neurological Society are open to all interested physicians and all allied health personnel. This meeting is approved for Category I credit. The Wisconsin Neurological Society is accredited for Continuing Medical Education credits.

Friday, October 26/8:00-10:00 pm

Dr Raymond W M Chun will preside over the usual, informal, and educational program aimed at the elucidation of various clinical and laboratory problems.

Saturday, October 27

9:00 am Hysterical Conversion Manifested as Parkinson's Disease. *Bhupendra Shah, MD*, Milwaukee.
9:25 am Skin Potential Response (SPR) in Neurologic Disorders. *William J Willems, MD* and *James W Albers, MD*, Milwaukee.
9:50 am Hexachlorbenzene Intoxication; Metabolic, Dermatologic and Neurologic Manifestations. *Henry A Peters, MD*, Madison.
10:20 am Coffee Break.
10:40 am Hyperphagia and Obesity Following Lesions of the Medial Hypothalamus in Man. *Gastone G Celesia, MD*, Madison, *Carol R Archer, MD* and *Hyung D Chung, MD*, St Louis, Missouri.
11:10 am To be announced.
11:45 am Lunch.
1:00 pm Myasthenia Gravis, Multiple Sclerosis and Overlap Syndrome. *Jack Petajan, MD, PhD*, Salt Lake City, Utah.
2:00 pm To be announced.
2:30 pm Vascularization of Isolated Muscle Fibers. *A R Sulaiman, MBBS, Kenneth Siegesmund, PhD* and *Debra S Kinder, HT*, Milwaukee.
3:00 pm Cutaneous Neuropathy in Lymphatoid Granulomatous Disease. *George Hambrook, MD* and *Robert Du Bois, MD*, Rockford, Illinois.
3:30 pm Post-Traumatic Migraine and Epilepsy. *Bhupendra Shah, MD*, Milwaukee and *Francis M Forster, MD*, Madison.
4:00 pm Business Meeting. *Dr Raymond W M Chun*, President.

The Wisconsin Neurological Society meets semi-annually, in late October and in May or June. The scientific meetings are open to all interested physicians. Members and guests are required to register so their attendance can be verified for accreditation for continuing medical education. Suggestions for improvement of the program are welcomed from members and guests.

1979 ANNUAL FALL MEETING, WISCONSIN SOCIETY OF PATHOLOGISTS, INC.
In association with the Section on Pathology, State Medical Society of Wisconsin

Saturday, Nov 10, 1979

Clinical Sciences Center, Main Auditorium G5/119, 600 Highland Ave, Madison, Wis

Morning Program: 10am-12 noon

The Value of the Liver Biopsy in Clinical Medicine, *Stanley Goldfarb, MD*, University of Wisconsin

Neonatal Heptatitis versus Biliary Artresia, *Gerard Odell, MD*, University of Wisconsin

Newer Diagnostic Techniques in Liver Disease, *Jack Kirshner, MD*, Marshfield Clinic

Afternoon Program: 2pm-5pm

Slide Seminar — Hepato-biliary Diseases, *George Hensley, MD*, University of Florida

Evening Program—5:30pm

Cocktails and Dinner, Inn on the Park, 22 North Carroll St, Madison, Wisconsin

Info: The Wisconsin Society of Pathologists, Inc, Mrs Elda Filter, Pathology Bldg, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5611

1979 Others

continued

Dec 1-6: American Academy of Dermatology, 38th Annual Meeting, Chicago, Ill, Conrad Hilton and Palmer House hotels. Meets criteria for Category I credit on an hour-for-hour basis for the PRA of the AMA. Info: AAD, Inc, 820 Davis St, Evanston, Ill 60201 (312/869-3954).

American Association of Medical Assistants, Wisconsin Society

Professional Development and Advancement Seminar

Saturday, November 3
Howard Johnson's Motor Lodge, Wausau

Speaker for morning session: *William Needler, PhD,* on "Job Search and the Medical Assistant."

Afternoon session presented by Mr Robert Intress, Assistant Director of Education, Marshfield Clinic, speaking on "CME and Relicensure, 1980."

Physicians who are experiencing problems of any kind with the Wisconsin CME Category I Program are cordially invited to attend this Seminar, or to register their medical assistants instead. Among the subjects to be covered will be: How to keep CME records; proper reporting of CME credits; and additional information as to where to send the CME credits, when it should be done, and the procedure which should be followed.

For further information, contact Carol Wiesner, CMA, Education Chairman, AAMA, Wisconsin Society, at Route 2, Box 168B, Black Creek, Wis 54106.

1980 Others

Jan 4-11: American Society of Clinical Pathologists, San Diego, Calif.

Jan 19-23: 36th Annual Congress, American College of Allergists, Americana Hotel, Bal Harbour, Miami Beach, Fl. Info: Frances P White, American College of Allergists, 2141 14th St, Boulder Colo 80302.

Mar 9-13: American College of Cardiology, Houston, Tex.

1979 AMA

Dec 2-5: House of Delegates, Honolulu, Hawaii. Contact: James H Sammons, MD, Exec Vice President, 535 N Dearborn, Chicago, IL 60610.
g2-10/79

1980 AMA

Jan 12-15: AMA Winter Scientific Meeting in San Antonio, Texas. Postgraduate courses, symposia, exhibits, and other events will be presented. (The annual convention of 1978 was the last to combine a meeting of the House of Delegates and the Scientific Program.)

U.S. Postal Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION of the *Wisconsin Medical Journal,* issued monthly.

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I certify that the statements made by me are correct and complete,
/s/ MARY ANGELL
Assistant Managing Editor

Date of filing: Sept. 20, 1979
PS Form 3526, modified above for purposes of printing.

Madison Seminars for Physicians Planned

Physicians can earn up to 22 1/2 hours of Category I continuing medical education credit by attending the Madison Seminars for Physicians this winter. These seminars are presented yearly by the SMS Commission on Continuing Medical Education and the Madison Chapter of the Wisconsin Academy of Family Physicians. Dates, locations, and topics of this year's programs are: Thursday, Dec 13, 1979, Madison General Hospital, NEW STANDARDS FOR CARDIOPULMONARY RESUSCITATION and EMERGENCY MEDICINE: Wednesday, Jan 16, 1980, St Mary's Hospital Medical Center, GERIATRIC MEDICINE; Thursday, Feb 21, 1980, Methodist Hospital, A DAY OF CARDIOLOGY; and Wednesday, Mar 12, 1980, UW Center for Health Sciences, A DAY OF CANCER PREVENTION AND THERAPY. For more information contact Bill Wendle or Arlene Meyer at SMS offices in Madison: 257-6781 or toll-free 800-362-9080. ■

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

HEW AGENTS: Consent or approval from the patient is not necessary to permit HEW agents to review medical records *if* the patient is covered by Medicare or Medicaid and the government has paid all or part of the bill.

REPORTING DEATHS: A Wisconsin physician recently completed a death certificate and noted that the patient had, what many would consider to be, an accident unrelated to the cause of death six weeks prior to the death. The Wisconsin Department of Health and Social Services stated that the death should have been reported consistent with Wisconsin laws which require that the following deaths must be reported immediately to the sheriff, police chief, or coroner of the county in which death occurs:

a) All deaths in which there are unexplained, unusual, or suspicious circumstances.
b) All homicides.
c) All suicides.
d) All deaths following an abortion.
e) All deaths due to poisoning, whether homicidal, suicidal, or accidental.
f) All deaths following accidents, whether the injury is or is not the primary cause of death.
g) When there was no physician in attendance within 30 days preceding death.
h) When a physician refuses to sign the death certificate.

This is printed here as a reminder, but the Society suggests reporting when there is any doubt as to the cause and effect relationship of an accident to the death.

IMPLIED CONSENT UPDATE: A recent opinion of the Wisconsin Attorney General on blood alcohol testing is basically consistent with the position of the Society and its legal counsel. In an article in the June 1978 *Wisconsin Medical Jòurnal* the details of the Wisconsin law were outlined and it was noted that, "The physician should not be reluctant to help the police secure objective evidence. It should be kept in mind that such evidence may help the accused just as it may hurt him. In any event the cause of justice is well served by the performance of this impartial function by the physician." The Attorney General's opinion makes it clear that if an individual is *under arrest,* the physician or other qualified health personnel should comply with the request of a law officer to administer tests including blood tests.

Under Wisconsin law, drivers who are unconscious or otherwise incapable of withdrawing their consent are presumed to have implied their consent to have the tests done. If the person is conscious and agrees, then the physician should proceed with the testing. If the person is conscious and in any way indicates s/he does not want the test, then the physician *should not* proceed. In complying with the request, the physician incurs no civil or criminal liability if the person is under arrest and there is no negligence in the technical performance of the test. The result of the test must be reported to the Department of Transportation, the law enforcement agency and the individual involved.

The State Medical Society has strongly urged law enforcement agencies to take the initiative for establishing working arrangements with physicians and hospitals for making the withdrawal of blood for chemical tests. Subjects for discussion in such initiatives are included in the June 1978 WMJ article. ▪

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WISCONSIN MEDICAL JOURNAL

NOVEMBER 1979

• Dying with your (or somebody else's) rights on • Clean indoor air—a fight for rights for health • High blood pressure control • Equity adjustments in Medicare profiles • Senile dementia • Gastric bypass • Understanding pain • Future of health care probed at October conference

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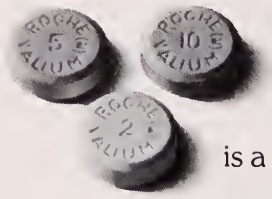
A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Before prescribing, please consult complete product information, a summary of which follows:

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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President's Page

Darold A Treffert, MD

Dying with your (or somebody else's) rights on

It was slightly over 100 years ago that an enlightened Wisconsin citizenry began to take the mentally ill from the jails, where they had been inappropriately incarcerated, and put them into hospitals where they could be treated. Thus began, in Wisconsin, the separation of the "mad" from the "bad." It was at that same time, a century ago, that Dr Walter Kempster, the first Superintendent of Winnebago State Hospital, wisely cautioned that "we must be certain always that we do not do irreparable harm to the mentally ill out of our unmitigated concern for their welfare."

Unfortunately, Wisconsin's present Mental Health Act, recodified in 1975 ostensibly out of concern for the mentally ill, has done just what Doctor Kempster warned about—produced irreparable harm. Commitment standards that are too harsh—that meet constitutional muster but fail to meet humane muster—procedures that are too cumbersome, and definitions that fail to balance clinical realities with legal rights have changed initial concern about patients' rights into an elaborate super-structure of what might better be called legal rites. These rites—"formal ceremonial acts"—have done nothing to alter, and certainly have not eradicated mental illness; rather they have merely caused the "bulge in the balloon" to shift from hospitals to jails. This shift is a regression from the effort of separating the "mad" from the "bad" appropriately begun, and applauded, 100 years ago.

Since the Lessard decision in 1970 with its totally unrealistic and out-of-touch commitment standards—"extreme likelihood that if the person is not confined he will do immediate physical harm to himself or others"—and since the rewrite of Chapter 51 to bring it into line with the Lessard decision in 1975, instance after instance has occurred in this state, as around the country, of situations where patients have, what I choose to call, "died with their rights on." These are situations in which scrupulous concern for the patients' rights have over-shadowed reasonable concern for the patient's life. Even more tragically and inexcusably, situation after situation has occurred, highlighted by the stabbing death of a 6-year-old boy in Milwaukee on his way to school, where some innocent person has died with somebody else's rights on. No matter the little boy's rights. These tragedies—entirely predictable and entirely preventable—are one part of this unfolding, ugly scenario. Related as well is the escalating phenomenon of mentally ill persons, formerly hospitalized on civil commitment criteria, now entering the system because of too stringent commitment criteria on criminal observation orders, having been arrested, booked, and jailed for minor offenses such as vagrancy, shoplifting, or disorderly conduct. At Winnebago, for example, forensic (criminal) admissions rose 260% following the Lessard decision and the subsequent rewrite of Chapter 51, the State's Mental Health Act. These are patients, flagrantly ill by anybody's standards, but who, as yet, fail to meet the dubious criteria of being imminently physically dangerous. They roam the streets unprotected, carrying their belongings in grocery sacks, reminiscent of a "return of the middle ages when the mentally ill roamed the streets and little boys threw rocks at them." Another writer recently characterized this inhumane scene as a "preservation of a liberty which is actually so destructive as to constitute another form of imprisonment."

Briefly stated is my position that the "freedom" to be penniless, helpless, ill, and finally arrested, jailed and criminally committed is not freedom at all—it's abandonment. The "right" to be demented, agonized, and terrorized in the face of treatment which cannot, because of legal prohibition, be applied is no right at all—it's a new form of imprisonment. The "liberty" to be naked in a padded cell with a cork floor, hallucinating, delusional, tormented, is not liberty—it is a folie a deux between pseudo-sophisticated liberals and an unrealizing public that if one changes the name of something to something else, or if you substitute a jail for a hospital, or if you substitute a preoccupation with legal rites for honest concern over patients' rights, one has done something significant, useful and important, or that one has done something at all.

Balancing the complex situation of whom of the mentally ill must be hospitalized is a difficult task at best and a treacherous one at worst. Somehow, however, all the elements of that equation need be given their proper weighting. These elements include not just the right to be free or the right to be sick but also the right to be rescued, the right of the family and of society to be free from the serious untoward effects of such illness, the right of the patient to due process, and the right of the patient to dignity as a human being.

We are struggling now to come to some reasonable middle ground between the right to be ill and the right to be rescued, just as we struggle in criminal law to somehow balance the criminal's rights with the rights of the victim. What is needed are changes in the law that will strike a delicate balance, a balance now missing and clearly weighted toward criminalization and toward legal rites. The State Medical Society's Committee on Mental Health is working with the Physicians Alliance, the Governmental Affairs Commission, and some key legislators toward correcting the present, sizeable defects in Chapter 51 to make it meet humane muster as well as constitutional muster. New, realistic commitment criteria need to be created; the minor's section needs to be revised; the section prohibiting treatment during detention needs to be altered; and the rights of the family and society at large need to be given equal weight, not more and not less, than the rights of the patient himself or herself. I am convinced the State Medical Society of Wisconsin can provide rational, and national, leadership in the delicate search for legislation that neither criminalizes nor captures the mentally ill, but rather helps psychiatry and the law take a cautious, new step forward in this important medical-legal area.

Man has never moved by plan. He has always moved by crisis. The pendulum has been the vehicle. A swing forward and a swing backward. Having reached the upward limit of too liberally defining illness and commitment, the pendulum now threatens to reach the other extreme. But the pendulum of history is a peculiar instrument. Like all pendulums, it swings to and fro. But somehow, almost imperceptibly, its forward excursions have always slightly exceeded the backward ones, and thus we as a people have managed to inch forward in an awkward gait. But we've moved backward recently, toward once again criminalizing the mentally ill, taking a stance I thought we had abandoned a century ago.

Perhaps the next time the pendulum swings forward it will propel us, gently, further than we have ever been before, so that we will reach a more sophisticated point of balance. ■

AMA-ERF contributions invited

The SMS Auxiliary's chairman of the American Medical Association-Education Research Foundation (AMA-ERF), Mrs Leslie H Stone of Oshkosh, is extending her annual invitation to physicians for contributions to the Foundation which supports medical education; provides financial assistance to medical students, interns, and residents; fosters scientific and medical research; and provides funds for rural and community-oriented pilot health projects. Of all the many worthy causes to which physicians may contribute, few can match AMA-ERF in providing such lasting and important benefits, Mrs Stone notes. She has submitted to *WMJ* a report which will appear in the December issue. Physicians are reminded that contributions to AMA-ERF are tax-deductible. Checks (payable to AMA-ERF "Auxiliary Fund") may be sent to: Mrs Leslie H Stone, 1835 Lake Breeze Road, Oshkosh, Wisconsin 54901. Please indicate that the contribution is for the Loan Guarantee Program and that it be earmarked for the medical school of your choice.

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1700 W Wisconsin Avenue
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Tel 414/931-4114

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University Hospitals
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Madison, WI 53792
Tel 608/262-3702

The three satellite centers are:

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Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

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P O Box 1221
Green Bay, WI 54305
Tel 414/432-8621

LaCrosse Poison Center
St Francis Hospital
709 South 10th Street
LaCrosse, WI 54601
Tel 608/784-3971

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the
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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal*, the official publication of the Society.

Editorials

Editorial Director: WAYNE J BOULANGER, MD

Confidentiality

SEVERAL YEARS AGO when PSROs were being organized, questions were raised by practicing physicians over the issue of confidentiality. We were promptly answered with assurances that the law guaranteed confidentiality of records, and most of us joined the PSROs because of that assurance, albeit hesitantly.

Now District Court Judge Gerhard Gesell, sitting in Washington, has ruled that information collected by PSROs can be made public.

You can rest assured that if Judge Gesell's ruling is allowed to stand, there will be mass resignation from PSROs and probably other peer review organizations and committees as well.

While there will undoubtedly be appeals of the decision and perhaps even re-writing of the legislation, the fact that a judge can even consider such a ruling should give us all pause. Those of us who function on hospital staff committees having to do with confidential information must in the future construct our records of those deliberations in such a fashion that even if they are released to the public, the patients whose records are released and the names of their physicians will be unidentifiable—and the next time someone tells us that if we don't set up our own PSROs or other similar organizations, the government will do it for us, let's sit back and let them!—WJB

Equal time

POLITICIANS DEMAND and are granted equal time. Although it is totally unrealistic and only a wild flight of imagination, what a spectacle one can conjure up!

Recently several magazines with circulations in the hundreds of thousands have been cluttered with six-page cigarette ads starting with the inside front cover. These present the usual macho tatooed cowhand pitch.

If we (the cancer and medical societies) could have equal time, think of the pictorial display of counter propaganda we could compose. A patient with terminal lung cancer coughing his bloody lungs out would be quite impressive. Or a cordon of pulmonary invalids with emphysema gasping on their respirators would be spectacular. Of course, we could make the presentation more appealing if the victims wore cowboy hats, were mustachioed, were appropriately tatooed, and had the exciting cigarette smoke curling about them. They would be gaunt enough without any staging!

Impossible, of course, but fun to contemplate.—VSF

It's not cricket

MEMORIES ARE SOMETIMES short. We should recall the chaos of 1975 when the malpractice insurance crisis confronted us. Then a group of dedicated physicians worked with the Legislature and the State Insurance Commissioner to create the Wisconsin Health Care Liability Insurance Plan (WHCLIP).

My own experience at that time is a vivid recollection. An insurance agent prevailed upon my partner and me to change insurance carriers to take advantage of a smaller premium. This was in effect for one year when the premium promptly went up, and after another year a claims-made policy was foisted upon us. We had no alternative. This was followed by three long, expensive years to buy out of that one-year coverage. The old reliable carrier we had had in the past refused to reinstate us despite our lily-white record. Fortunately for us, the WHCLIP came along at that point.

The record of WHCLIP has been very good, and in the first two years there were substantial decreases in the premium level. In fact, because of this experience in the improved climate, the large commercial carriers have taken a renewed interest in selling their policies in Wisconsin.

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

There are only 6,000 physicians practicing in Wisconsin. All are required by law to be adequately protected with liability insurance. Approximately half of these physicians are covered by WHCLIP. Thus, there is a relatively limited market in this field.

Right now there is a corporation consisting of several Wisconsin physicians and other persons requesting permission from the State Insurance Commissioner to form another insurance company to provide physicians' liability coverage. This proposed new company has the advantage of the actuarial experience and expertise of the WHCLIP. They propose to sell policies for 5% less than WHCLIP. In these days of 12% to 14% interest rates, that 5% doesn't seem mightily magnanimous! The proposed new company would insure only a "select" group of physicians, and not physicians who treat the so-called "high risk" patient. This could conceivably result in WHCLIP being left with physicians in the higher risk specialties.

A physician should be aware of this potential return to the chaos of 1975. They should not be influenced by the possibility of a meager 5% savings in premiums.

When one recalls that WHCLIP bailed out a lot of distressed physicians, it should stimulate a sense of loyalty to that plan. Remember that the new corporation and a projected secondary interlocking corporation, despite the altruistic prospectus, is a "for-profit" insurance company. And it is projecting a 50% growth rate!

It's just not cricket to abandon an old friend!
—VSF

Too little legislation?

During the month of September there were five deaths on the Surgical Service at Columbia Hospital in Milwaukee. Three of the patients who died were in their mid-80s; the other two were ages 19 and 31. The octogenarians died of illnesses related directly to their ages; so did the other two, in a way, for the other two were motorcyclists who died of injuries sustained in collisions with other vehicles. *They had not been wearing helmets at the moment of impact.*

At the monthly surgical death conference during discussion of this endemic problem, the attending neurosurgeon was asked what measures Milwaukee neurosurgeons had taken with regard to prevention of further waste of healthy young lives. He replied that letters had been written to legislators deploring the lack of a stringent helmet law in Wisconsin, but that the campaign hadn't been very effective. That's sad.

It's sad because our legislators are aware of the magnitude of injuries to motorcyclists. And they are aware that many motorcyclists don't have sufficient foresight to wear helmets voluntarily. They argue that forcing a cyclist to wear a helmet is in violation of his rights. They fail to see that some "rights" must occasionally be abrogated if it is for the greater good—just as our individual "rights" to drive 65 miles an hour were given up to preserve fuel (not to preserve life and limb, curiously).

Why our legislators can't act responsibly in this issue is difficult to understand. It can't be because of their reluctance to legislate—at least they haven't shown any reluctance in other areas. We have no alternative but to keep after them until constructive action is taken. Perhaps with the force of law behind them those health care professionals who have to take care of the injured motorcyclists could work out some sort of motorcycle safety course complete with visits to intensive care units prior to certification. The motor vehicle division could require taking such a course as a condition to licensure of the motorcycle.—WJB

Unmitigated gall

The Dane County Bar Association publishes a very sprightly newsletter. In a recent issue the editor indicated there have been many inquiries addressed to the Association Brass about the Newsletter's reporting, outrageous stories and plain, unmitigated gall.

The editor responded by saying that the Newsletter's avowed purpose was to eventually irritate enough readers so that the Editor would be replaced through sheer weight of indignation. The editorial policy is to reduce the self-esteem of all those persons whose sense of importance has swollen to the bursting point (like lawyers, judges and governors—especially governors of the organization).

The last time a medical journal editor wrote an editorial asking for suggestions and criticisms and even offering to resign his position, that journal ceased publication the following month. The response must have been overwhelming.

The bar association newsletter might be a bit brash for a medical society publication. However, it is certainly lively and I am sure widely read by its membership. I wonder if physicians would tolerate the informality and ribbing. Perhaps a trial run in the Medigram or in some section of the *Wisconsin Medical Journal,* other than the scientific papers, might prove stimulating.—VSF

Go slow on subsidies

In 1978 when the issue of advertising by the legal and medical professions was being widely discussed, one of the standard arguments in favor had to do with the possibility that advertising would bring competition out into the open and somehow that healthy competition would cause a lowering of fees.

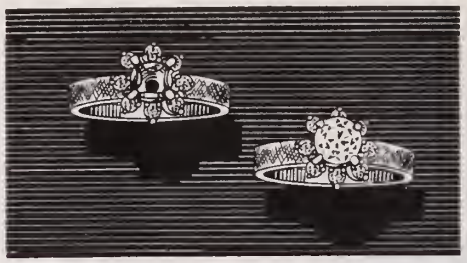
Well, there really hasn't been much advertising in either of the professions, and fees have generally kept pace with the inflation rate.

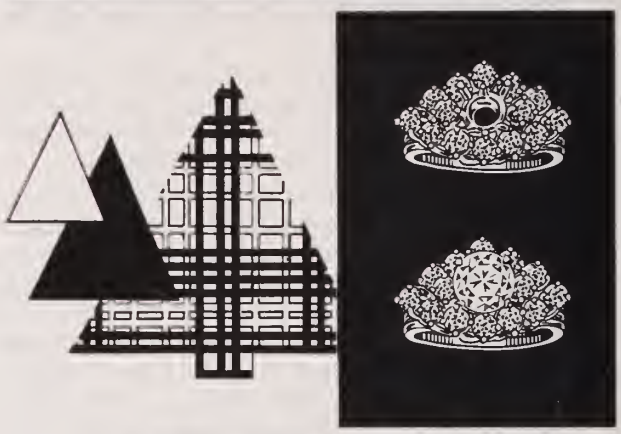
There has been a noticeable change in hospitals, however. They have become much more aggressive in their approach to the public as they compete for patients. A wide array of courses has been offered by hospitals as public relations ventures, and regardless of the motivation behind them, they have constituted excellent public service and have been well-received. Unfortunately, while CPR courses, blood pressure clinics, and the like may be effective and enhance the hospitals' image, if anything they keep beds empty rather than full.

It didn't take long for hospital leadership to recognize that patients don't hospitalize themselves. They are brought in by primary-care physicians. The obvious conclusion is drawn: enlarge the staff—recruit primary-care physicians. All of a sudden the primary-care physician became as valuable as a shortstop who could hit .300. Judging from recent news items, some hospitals have actually offered low-interest loans and grants or rent-free office space to entice young graduates or even established physicians with built-in practices.

To a hospital board this might seem to be good business, and in the short term it might prove effective, aiding both the hospital and the subsidized physician. But for every grant recipient there will be many more physicians on the same staff who have had to start out in their practices without such help and who also may not yet have developed their own practices to a degree where competition from the subsidized physician won't hurt. In the long run the immediate gains by the hospital may be offset by the departure of these independent physicians with the subsequent damage to staff continuity and morale.

It would be better if hospital staff leadership remained patient awhile longer, and continued to try to attract young talent the old fashioned way—by making the hospital a stimulating, exciting, comfortable place in which to take care of the sick.—WJB ■





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Letters

Physician's widow . . . oops, spouse

In the most recent annual Blue Book issue I found it somewhat amusing that you should address your article, "The Problems of a Physician's Widow." I would presume that the same problems would be encountered by a physician's spouse no matter what the gender and suggest that this article may be helpful not only to the wives of physicians but also to the husbands of physicians as they certainly would have similar problems in the event of the death of their physician wife.

For this reason I have suggested that my husband place this article in a file and would suggest that other physicians of my gender consider doing the same for their husbands.

Marcia J S Richards, MD
Milwaukee, Wisconsin

Editor's note: Doctor Richards point is well taken. The article to which she refers above has been published annually in the Blue Book issue, with periodic updating of the content, for many years. Unfortunately we failed to update the title as more women became physicians in recent years. The letter has been placed in our pending file for the 1980 Blue Book updating.

Medical school class size freeze

I happened to pick up the February '79 issue of your Journal and felt compelled to write. There is a very "interesting" article in it under the "Organizational/SMS" column entitled "SMS commission backs medical school freeze."

SMS rationale for freezing current class size is so that there won't be an oversupply of physicians (how dreadful!) and so there won't be increased medical costs. Seems funny—my husband raises beef cattle for a living, and whenever there's an oversupply the price goes *down!* Theoretically, according to law of supply and demand, the same should hold true to physicians.

Sorry, but I don't buy SMS' limp excuses. It's pretty obvious as to why SMS wants the class size frozen. I guess cattlemen should become as smart as physicians and limit yearly calf production when oversupply seems imminent (for the good of the consumer, of course).

I hope the carbon of this letter doesn't reach Governor Dreyfus' office too late for registration of one more opinion on the subject before the matter is closed.

Think I'll read this Journal more often as my husband and I could learn something.

Beverly A Krueger
Blue Mounds, Wisconsin

cc: Governor Lee Dreyfus

Editor's note: Experience and data indicate that the traditional market forces of supply and demand do not always hold true in the medical/health field. In fact, some reports indicate that with the over supply of physicians, medical prices and costs increase. The Health Planning Commission felt that the medical school class size freeze was a first step in planning more accurately for health manpower needs which in the long run will help reduce healthcare costs. Governor Dreyfus succeeded in initiating such a policy in his biennial budget. All of us hope that it will help in achieving for Wisconsin citizens the highest quality of healthcare for the lowest price. ▪

The Editors would like to encourage physicians to contribute to the LETTERS TO THE EDITOR section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

In Perspective

BRIAN JENSEN, Director
Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

Clean indoor air—a fight for rights for health —not unwarranted government intervention

THE HEALTH HAZARDS, both real and potential, from breathing the smoke of other people's cigarettes and cigars are indisputable in the minds of many patients with asthma and chronic bronchitis. These patients (7-10% of the general population) suffer increased cough, sputum production, rhinorrhea, wheezing, and shortness of breath when exposed to the noxious fumes of sidestream smoke. All of us, even without those diseases, often complain of a burning sensation in the nose, watering of the eyes, rhinorrhea, and general unpleasantness when forced to breathe so-called sidestream smoke. Even smokers complain when the smoke from their burning cigarette is blown back into their face.

But is clean air worthwhile? Or are these complaints aired only by whimpering, molly-coddled malcontents? The haze produced by a smoke screen of advertising on the one hand and cries of foul air on the other hand has made rational evaluation of the desirability for clean indoor air difficult at the least. The Environmental Health Committee of the Governmental Affairs Commission of the State Medical Society has tried to address this issue in relationship to the proposed Clean Indoor Air Bill, Senate Bill 80, and its watered-down counterpart, Assembly Bill 80, currently being considered in the Legislature. The Committee unanimously endorsed the concepts and proposals of Senate Bill 80 which would provide for areas for smoking and for nonsmoking in public places, including government buildings, hospitals, and large restaurants. Politically, similar legislation has worked well in many states, including our neighboring Minnesota. Recently, the Joint Finance Committee recommended passage, but floor action returned the bill to the committee of Senator Timothy Cullen (D-Janesville) on Aging, Business and Financial Institutions and Transportation.

The issues boil down to (1) the health effects of sidestream smoke in normal people, (2) the health effects on super-sensitive people, and (3) the economics involved. Sidestream smoke is that smoke that comes from the cigarette while it is not being inhaled by the smoker. As it wafts up into the air around the smoker, representing about 50% of the tobacco burned, it is responsible for delivering approximately two-thirds of the aerosol particles impacted on the environment. This smoke contains approximately 2,000 identifiable components in either gas or particulate phase. Trace components and gaseous products are available for inhalation by the nearly nonsmoker.[1]

Studies looking at measurable health effects of tobacco on nonsmokers have been slow to come about and few in number, yet data has accumulated showing an increased prevalence of respiratory disease in young children whose parents smoke.[2] Data showing an increase in carbon monoxide level in the blood has been more recently evaluated: not only does the carbon monoxide level of the blood increase 50-100% above baseline levels in nonsmokers sitting in unventilated rooms with smokers but also patients with angina pectoris in such situations have been shown to significantly decrease their exercise tolerance to the point of angina after being exposed to sidestream smoke.[3] NIOSH has proposed a maximum acceptable ambient carbon monoxide level of nine parts per million for industrial exposure. Many studies have shown levels to be higher than this by three to four times in smoky rooms. Since the hemoglobin affinity for carbon monoxide is approximately 210 times that for oxygen, blood levels rise even with slight increases in the inspired air. The long-term implications of this carbon monoxide exposure alone are probably much more serious in relationship to the prevalence of arteriosclerotic disease in the population than almost any other environmental exposure we can talk of. Carbon monoxide has been shown in many studies over the years to increase atherogenesis.[4]

The health effects on patients who are supersensitive to the irritant effects of sidestream-smoke are sufficient to precipitate prolonged bouts of bronchospasm and cough and to discourage patients from going out to eat or participate in

senior citizen groups, or visit in any of their legislators' offices.

The financial implications of this bill are not staggering. The fiscal impact of asking businesses and government agencies to provide signs and areas for smoking and for nonsmoking separately is negligible for any one business and a drop in the bucket for our government buildings. Yet in 1976 US Government agencies willingly spent 200 million dollars on pollution control measures to try to control the *outside* air. In 1978 the tobacco industry spent 800 million dollars just in advertising tobacco products and the American public spent as much money buying tobacco as it did paying doctor bills.

Urging our legislators to provide pollution control of our indoor air can result in good health effects at almost no public expense. Passage of this bill would *not* produce the oft talked about unwarranted government regulation. Let's buy clean air legislation; no where else is such a good price-earnings ratio available!

—**Larry A Lindesmith, MD**, LaCrosse
Member, Committee on Environmental Health

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3. Aronow WS: Effect of passive smoking on angina pectoris. *N Engl J Med* 299(1):21-24, 1978.
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High Blood Pressure Control

Wisconsin High Blood Pressure Control Program—involving the physician

George H Handy, MD, Madison; **Richard Dart, MD,** Marshfield and **Audrey Koehn,** Madison, Wisconsin

MORE THAN ONE-HALF million Wisconsin residents are afflicted with one of today's major health problems—high blood pressure. Statistics indicate that almost half of these individuals are unaware of their condition and another third are not following their treatment.

Uncontrolled high blood pressure is considered the most important risk factor in the development of stroke and congestive heart failure. Although high blood pressure incidence increases with age, children and those "in the prime of life" are affected in large numbers.

High blood pressure is clinically defined as *sustained* readings in the following ranges:

AGE	BLOOD PRESSURE *Systolic/Diastolic*
18-49	140/ 90
50 & up	160/ 95
Any Age	Diastolic - 120

High blood pressure can be controlled and its effects lessened through appropriate intervention methods. Epidemiologic studies have identified factors which predispose certain population groups to increased disability and death due to cardiovascular disease. In addition to etiologic factors; heredity, psychological and socioeconomic characteristics are critical elements. Therefore, intervention must be broadly based to affect all these known risk factors.

Effective high blood pressure control in Wisconsin faces problems that deal directly with intervention processes. Most difficulties arise from widespread misunderstandings of the nature of this chronic disease by healthcare providers, patients, and the general public. Intervention often fails to bring the disease under control because:

1. Individuals are unaware that they have high blood pressure.
2. Individuals misunderstand the importance of control.
3. Individuals have insufficient motivation to seek or comply with treatment.
4. Providers, patients and the public fail to recognize and/or accept the importance of continual monitoring and long-term management of high blood pressure.

In the last several years public health nursing agencies, health professionals, service organizations, hospitals, voluntary health agencies, and others have engaged in and carried out various blood pressure programs. Their intervention methods ranged from mass screening, community education, professional and volunteer training to comprehensive detection, referral, treatment and followup programs. However, few programs had coordinated their control activities with others. Various methods and standards were used for measuring blood pressure, detecting high blood pressure, and referring individuals for possible diagnosis and treatment. Most programs failed to followup patients to encourage ongoing treatment of high blood pressure.

To encourage and coordinate high blood pressure activities and, as a result of federal categorical grant support to states for "screening, detection, diagnosis, prevention, and referral for treatment of hypertension," the Wisconsin High Blood Pressure Control Program was established in January 1978. This program promotes the use of nationally recommended uniform criteria on detection, referral, diagnosis, treatment, and

Doctor Handy is the State Medical Society of Wisconsin representative to the State Blood Pressure Advisory Council. Doctor Dart is a member of the State Blood Pressure Advisory Council. Ms Koehn is a staff member of the Bureau of Prevention-Wisconsin Division of Health. Reprint requests to: Bureau of Prevention-Wisconsin Division of Health, PO Box 309, Madison, Wis 53701. Copyright 1979 by the State Medical Society of Wisconsin.

long-term management, and encourages the use of educational components designed to provide patients, families, and the public with the information necessary to make their own health decisions.

A State High Blood Pressure Advisory Council was established to advise the Administrator of the Division of Health, assist in High Blood Pressure Control Program efforts, and create statewide awareness of the need for control of high blood pressure. The State Medical Society of Wisconsin is represented on the Council along with several organizations which represent the ethnic, geographic, and economic makeup of the state.

The basic aim of the state program is to coordinate existing health resources for blood pressure control through local, geographic networks—such as a county—that can incorporate state criteria for high blood pressure detection, referral, patient education, and compilation of statistics for entry on the state data system. Any program which becomes part of the state program will adopt the uniform method for blood pressure measurement, detection and referral; patient education counseling; and use of the data system to use in demonstrating program participation rates and to use in tracking those individuals with high blood pressure.

Generally, local public health agencies serve to organize local blood pressure programs and networks. They must mobilize the health service providers and community leaders to participate in the state coordination effort through the organization of a local advisory council for high blood pressure. The local council and agency then have the responsibility for promoting the standards of the state program with the agency responsible for high blood pressure tracking and control activities. However, before detection activities can begin, the local blood pressure program must insure the cooperation and participation by local physicians, hospitals, nurses, and other members of the medical community so that referred patients will be accepted. Referral criteria used by the local program must comply with state program standards which are:

Screen 1:
- Normal - recommend blood pressure check annually.
- Elevated - checked again within one week.
- Diastolic - 120 - emergency referral to physician or clinic.

Screen 2:
- Normal - 3rd reading indicated.
- Elevated - refer to physician for evaluation.
- Diastolic - 120 emergency referral.

Screen 3:
- Normal - advise blood pressure check semiannually.
- Elevated - refer to physician for evaluation.
- Diastolic - 120 - emergency referral.

Recheck:
- *Not under physician's care*
- Normal - recommend semiannual blood pressure checks.
- Elevated - recheck within one week.

- *Under physician's care*
- Normal - reinforce continuing physician's orders, encourage regular visits to physician.
- Elevated - find out if complying with treatment and encourage them to check with physician.

Referral cards are sent to physicians with the patient's name, blood pressure clinic number and

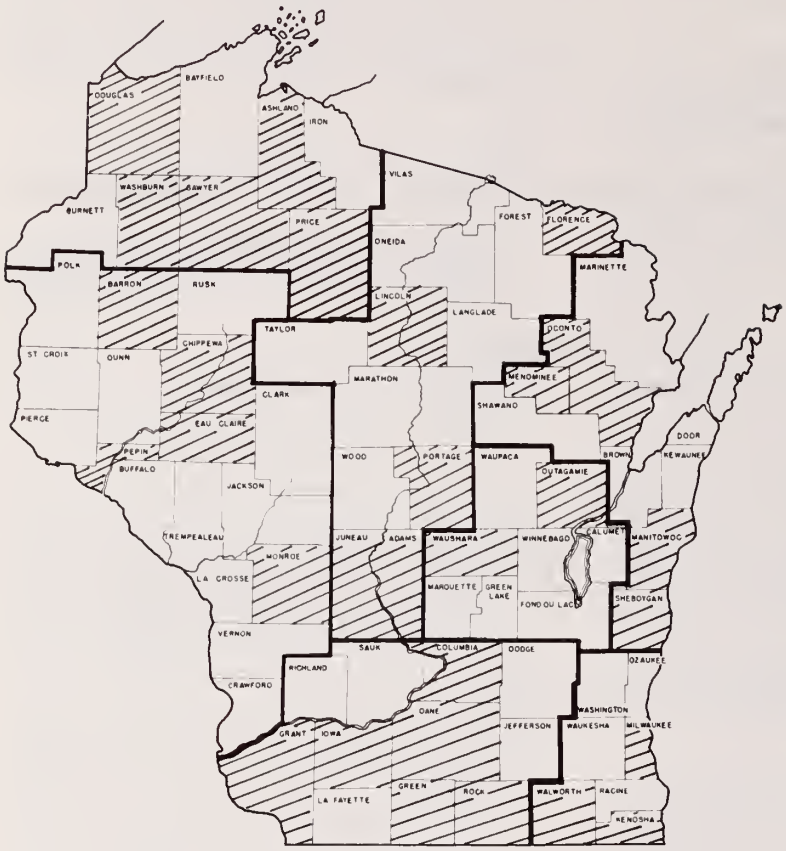
Society of Critical Care Medicine

Ninth Annual Scientific and Educational Symposium, San Antonio, Texas, Convention Center, May 12-16, 1980.

Third World Congress on Intensive Care Medicine/Tenth Annual Scientific and Educational Symposium, Washington, DC, Washington Hilton Hotel, May 25-29, 1981.

Eleventh Annual Scientific and Educational Symposium, St Louis, Missouri, Stouffer's Hotel, May 24-28, 1982.

Contact: Norma Shoemaker, RN, MN, Box 3158, Anaheim, CA 92803.



Wisconsin counties with high- risk populations:

Adams	Manitowoc
Ashland	Menominee
Barron	Milwaukee
Chippewa	Monroe
Columbia	Oconto
Dane	Outagamie
Douglas	Pepin
Eau Claire	Portage
Florence	Price
Grant	Rock
Green	Sawyer
Iowa	Sheboygan
Juneau	Walworth
Kenosha	Washburn
Lincoln	Waushara

dated blood pressure measurements by the local blood pressure program. Physicians are asked to complete and return the lower half of the postcard to the local blood pressure program.

In addition, physicians are encouraged to utilize the local blood pressure programs to assist in the education of patients, provide blood pressure checks to patients and to track the patient in order to help the patient stay under good control. These direct services are provided free of charge to patients and may provide incentive for them to comply with their treatment regimens.

The Division of Health provides funding up to three years to assist in the establishment and maintenance of community programs to control high blood pressure through federal monies received (Public Health Service Act to State Project Grants). Those programs receiving grants at the time of this writing include:

- Brown County/ Green Bay City
- Fond du Lac City
- Eau Claire City/ County
- Milwaukee County
- Grant County
- Menominee County
- Iowa County
- Lafayette County
- Sawyer County

The State High Blood Pressure Control Program hopes that by 1984 community blood pressure programs will be established in 54 of the 72 counties in Wisconsin which have 90 percent of the estimated high blood pressure population. Priority will be given to the 30 identified counties which have significantly higher age-adjusted mortality rates for heart disease and stroke compared to state rates.

It should be remembered that the Wisconsin Blood Pressure Control Program can be successful only if there is a good understanding and cooperation between physicians, other healthcare providers, and local blood pressure programs.

Please contact the State Blood Pressure Control Program (608/266-1251) if you have any questions or comments at Wisconsin Division of Health, PO Box 309, Madison, Wisconsin 53701.

References

- State Health Plan—Wisconsin High Blood Pressure Control Program, January 1979, Wisconsin Division of Health, Bureau of Prevention.
- Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure, USDHEW, Public Health Service, National Institutes of Health, Publication No. (NIH) 77-1088. ■

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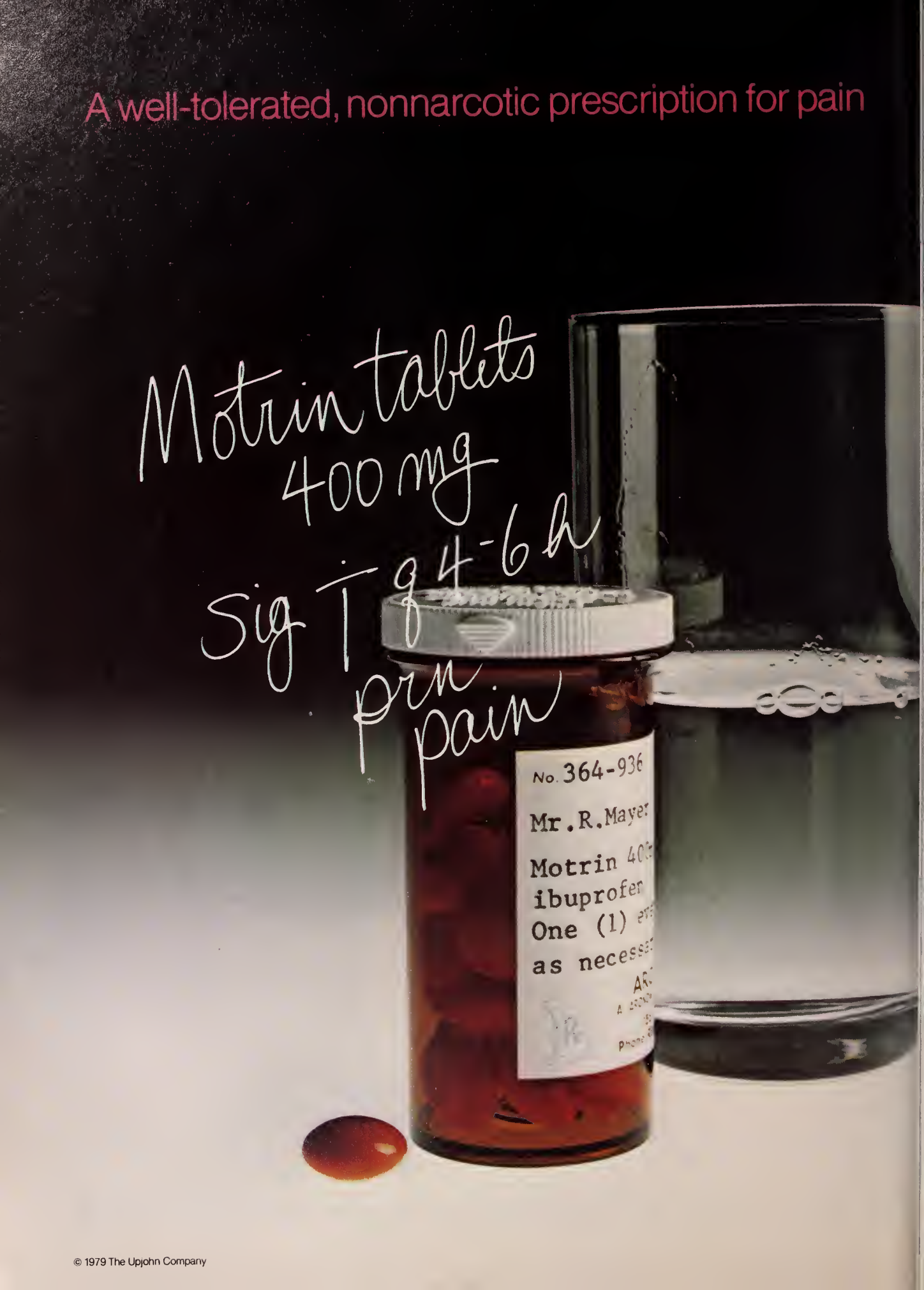
The Upjohn Company announces a new indication for Motrin®
(ibuprofen)

A well-tolerated, nonnarcotic prescription for pain



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Motrin now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400 mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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August, 1979

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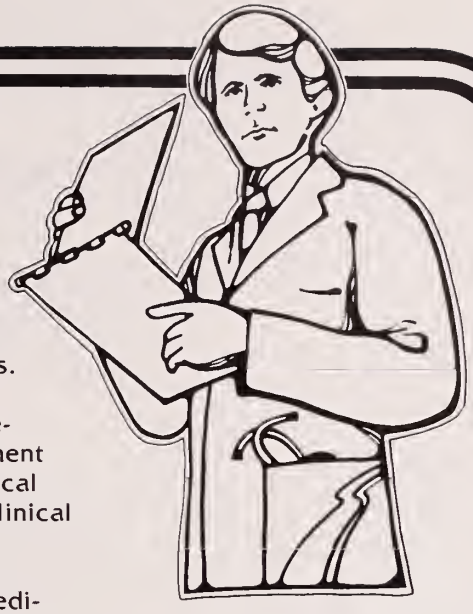

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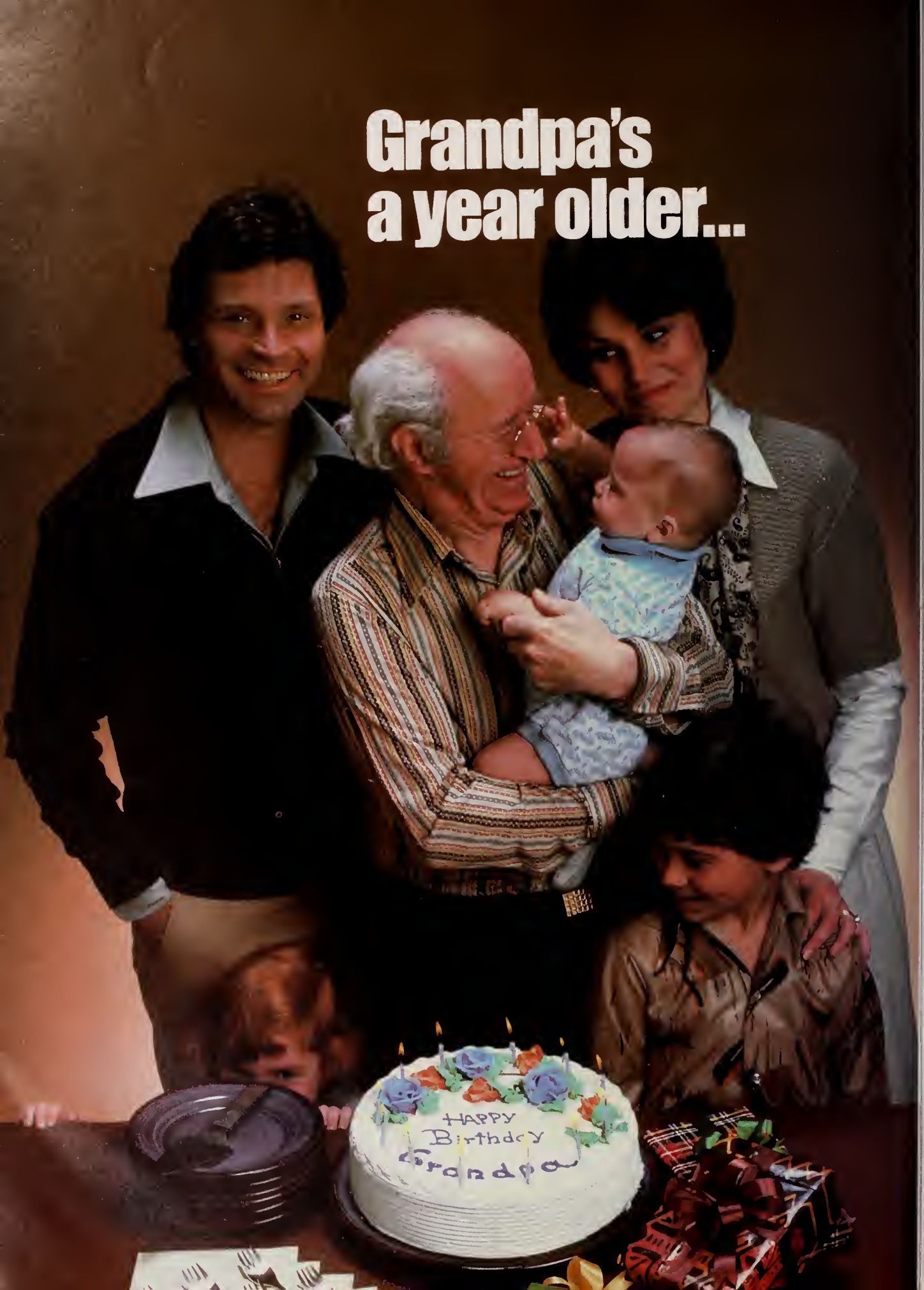
Grandpa's a year older...



and at greater risk from pneumococcal pneumonia

The risks rise sharply with the years—

Although pneumococcal pneumonia can occur at any age, it is often more serious for older patients. Elderly patients are at greater risk of developing severe bacteremic infection; hospitalization is often required and recovery may be prolonged.
Your elderly patients with pneumococcal pneumonia also have a significantly higher mortality rate—despite antibiotic therapy.

Vaccination with PNEUMOVAX can significantly reduce the incidence, as well as the considerable economic cost, of pneumococcal pneumonia. For your elderly patients, it offers protection against a serious and frequently debilitating illness.

PNEUMOVAX is also useful for other patients at high risk: *persons having chronic physical conditions* such as chronic heart disease of any etiology, chronic broncho-pulmonary disease, chronic renal failure, diabetes mellitus, and other chronic metabolic disorders; *persons convalescing from severe disease; persons in chronic care facilities.*

PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. *Adverse reactions* include local erythema and soreness at the injection site; low-grade fever occurs occasionally. *PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine.* Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

More than ever he may need

PNEUMOVAX®

(Pneumococcal Vaccine, Polyvalent | MSD)

MSD
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Please see following page for summary of prescribing information.

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PNEUMOVAX®

(Pneumococcal Vaccine, Polyvalent|MSD)

INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: *PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).*

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature	Pneumococcal Types													
U.S.	1	2	3	4	6	8	9	12	14	19	23	25	51	56
Danish	1	2	3	4	6A	8	9N	12F	14	19F	23F	25	7F	18C

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported.

Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe

Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials

For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

J9PX12 (DC 7014803)

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For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective, as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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In irritable bowel syndrome*

Adjunctive

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Each capsule contains
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antianxiety/antispasmodic/antimotility

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

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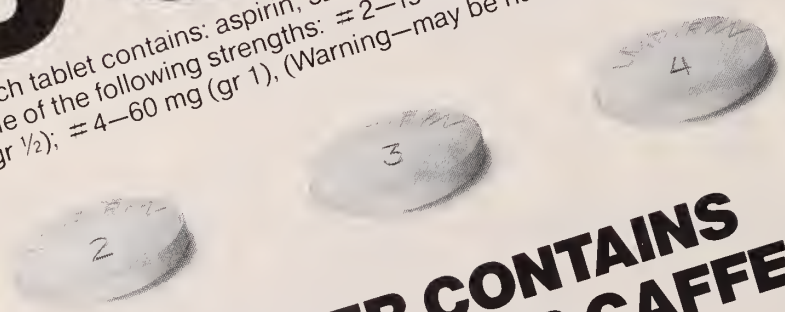
Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: #2—15 mg (gr ¼); #3—30 mg (gr ½); #4—60 mg (gr 1), (Warning—may be habit-forming)



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Scientific Medicine

REFER TO: Fisk AA: Senile dementia, Alzheimer-type (SDAT): a review of present knowledge. *Wisconsin Med J* 78:29-33 (Nov) 1979

KEY WORDS: Dementia, senility, Alzheimer-type dementia, organic brain syndrome, arteriosclerosis

Senile dementia, Alzheimer-type (SDAT) A review of present knowledge

Albert A Fisk, MD, Milwaukee, Wisconsin

DEMENTIA IS THE major disabling disease of the elderly, responsible for an enormous amount of suffering; yet it remains one of the least well understood illnesses by both the general public and physicians. It also is a critical factor in many other illnesses, particularly in the rehabilitation potential of elderly patients developing fractures of the hip, strokes, and congestive heart failure. It is the status of the mind, not the status of the heart, the kidneys, or other organs which is usually the major limiting factor in the ability of the elderly patient to make a satisfactory recovery from his illness.

In addition, dementia is a cause of tremendous tension and agony within the family group when one of the members becomes demented. Consider for example a couple in their 80s who have been married for 60 years. Should the wife become seriously demented, it is difficult for the husband to understand this paranoid, agitated elderly woman who cannot remember from one moment to the other what she did or what she should do. He assumes a terrible burden taking care of her and is emotionally overwhelmed. Therefore, it is important for us to understand this illness that represents such a problem in our growing elderly population.

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The diagnosis of dementia rests on three pillars: intellectual factors, psychiatric factors, and somatic and neurologic factors. Of the intellectual factors, the most striking defect is in the memory. There is a benign recent memory loss characteristic of most elderly people, unassociated with dementia, and felt to be part of the normal aging process. The memory loss of the demented patient starts out as a recent memory loss, but becomes progressive and eventually massive to the point where the patient can remember nothing from minute to minute or from year to year. Associated with this memory loss is confusion and disorientation to the point that the patient does not know where he is, what time it is, what year it is, or eventually, who he is. In addition, there is a general intellectual deterioration affecting such items as judgment and ability to calculate. It is just the intellectual attributes that differentiate man from his fellow animals that are affected most acutely in the dementing process.

The psychiatric factors most prominently associated with dementia are irritability, agitation, and hostility. Paranoid reactions become very prominent, although the presence of paranoia in the elderly is not diagnostic of dementia. There are many paranoid elderly patients who remain intellectually quite competent. Many demented patients wander away from nursing homes or from their own homes, and into neighbor's houses unexpectedly with resulting problems.

The somatic and neurologic factors are equally striking and show that dementia is indeed an illness rather than just a state of mind. Patients

suffer from weakness, anorexia, and weight loss. There is evidence of cortical involvement with aphasias and appraxias. The demented patient develops a short-stepped gait and frequently is bent over as he walks, looking at the ground. The aphasias may progress to true mutism. Incontinence of urine and feces is frequently present and is one of the major factors leading to institutionalization of the elderly patient. The inability to manage the activities of daily living results in poor hygiene, urinary catheters, and inability to raise secretions from the lungs. All result in infections. Infections of the urinary tract with secondary sepsis are probably the most frequent cause of death in the demented patient. Decubiti with secondary sepsis and bronchial pneumonia also are common.

Primitive reflexes are common, but not diagnostic of dementia. Many demented patients have very strong grasp reflexes. Stroking the palm of the hand results in a grasp that will allow one to raise the demented patient from lying to a sitting position. Equally positive may be sucking, snout, and palmomental reflexes. Two point discrimination is decreased and double simultaneous stimulation results in abnormal responses.

It is this combination of intellectual, psychiatric, and somatic and neurologic factors which represents the clinical picture of dementia in the elderly. The diagnosis of dementia remains a clinical one. There is no single test, no IQ test or CT scan, that makes the diagnosis of dementia certain.

In 1966, almost 30% of psychiatric patients in the United States were found to be older than 65 years.[1] It was estimated that 78% of these patients had organic brain syndrome, indicating that a large percentage of the psychiatric beds in the United States are occupied by demented elderly patients. Approximately 2.3% of the elderly require institutionalization for dementia; this represents almost half of the institutionalized population of the elderly. It is now estimated that there are 2 million elderly with mild dementia, or approximately 10% of the elderly population, and that there are 1 million elderly with severe dementia. By the year 2000, the number of elderly demented patients is expected to increase by 50% so that we will have 3 million with mild dementia and 1.5 million with severe dementia. This increase is due to the expected large increase in the number of elderly in the 75 to 85-year-old age group. Contrast this with the infinitesimally small number of psychiatrists specializing in geriatric psychiatry, at most half of 1%. Most of these psychiatrists have not had specialized training in geriatric psychiatry, but represent psychiatrists who have taken positions in state hospitals.

Although Katzman[2] has estimated that dementia is the fourth or fifth most common cause of death in the United States, it is not mentioned in

Table 2—Causes of senile dementia

Some correctable causes
Depression
Drug toxicity, especially psychotropic agents
Normal pressure hydrocephalus
Benign intracranial mass, including subdural
Hyper- and Hypothyroidism
Pernicious anemia, pellagra, Korsakov's syndrome

Metabolic disturbances:
- Hepatic failure
- Respiratory failure
- Uremia
- Hypercalcemia

Some treatable causes
Huntington's chorea
Syphilis
Malignant brain tumor
Herpes encephalitis

Untreatable
Pick's disease
Crutzfeldt-Jakob disease

Table 1—Tomlinson's pathological classification of dementia in old age[4]

	Percent
Senile dementia (Alzheimer's disease in old age)	50
Arteriosclerotic (ischemic) dementia	12
Mixed senile and arteriosclerotic dementia	8
Probably arteriosclerotic dementia	6
Probably mixed senile and arteriosclerotic dementia	10
Unclassified (possibly related to senile dementia)	6
Other specific causes	4
No morphological changes	4
	Years
Mean age-senile dementia (25 cases)	80
Mean age in arteriosclerotic dementia (6 cases)	65

Table 3—Pathological changes SDAT

1. **General Findings:**
   (a) Cerebral atrophy, especially in frontal and temporal regions, resulting in large ventricles and widened sulci
   (b) Neuron loss in SDAT:
   55% Mean loss of neurons
   70% Loss in deeper layers of cortex

2. **Microscopic Findings:**
   (a) The neurofibrillary tangle—A mass of fibrils-filling neuron—characteristic, but not diagnostic of SDAT. Composed of bundles of paired helical filaments (PHF) 10-13 nm in diameter—"Twisted Tubules."
   (b) The senile plaque, the center of which is composed of extracellular amyloid, type B.
   (c) Granulovascular degeneration of hippocampus

vital statistics. That is because the demented patients die of infection and other acute illnesses. The average age of onset of senile dementia, Alzheimer-type (SDAT), is 74 years with life expectancy 5.1 years, normal being 9.6 years. This decrease in life expectancy by 50% indicates that the diagnosis of SDAT is a serious one and should be considered as important as making a diagnosis of congestive heart failure, or cancer.

Multi-infarct dementia starts at a younger age, average 66.8 years, but the life expectancy is even less, 3.8 years, with the normal life expectancy being 14 years. Marked reduction in life expectancy is associated with the presence of arteriosclerosis and many die of myocardial infarction.

Table 1 represents the Tomlinson[3,4] classification of dementia based on careful pathological studies that he did in England in 1968 and 1970. It is apparent that about two-thirds of demented patients will have SDAT. This type of dementia is pathologically indistinguishable from Alzheimer's presenile dementia, and it is now felt by pathologists and knowledgable clinicians that the two diseases are probably the same. The present term, senile dementia, Alzheimer-type, has been selected as the preferable term to replace the less specific terms, senile dementia and organic brain syndrome. The SDAT patient is usually female, and older than 70. Multi-infarct dementia due to arteriosclerosis accounts for less than one-third of demented patients. They are usually male, in their late 60s, suffering from chronic hypertension. Multi-infarct dementia runs a fluctuating course and is characterized by focal signs such as hemiparesis and by pseudobulbar palsy. Multi-infarct dementia may be due to large infarcts or may be the result of multiple lacunar infarcts associated with chronic hypertension.

FIGURE 1—Coronal section of brain of demented 83-year-old patient. Note narrowing of cortical ribbon (printed by permission[6]).

Although other types of dementia account for less than 4% of the total, they represent an important group represented in Table 2. Of the correctable and treatable causes of dementia, depression and drug toxicity are the most common and are the ones that every physician should consider. Since many demented patients are depressed, it is difficult to differentiate between depression as a primary affective disorder in the elderly and depression associated with dementia. A psychiatric evaluation may be helpful and it may be useful to give antidepressant therapy a clinical trial. Depressed patients may have a marked reduction in mental function, but such a decrease in intellect is temporary. When the depression lifts, the mind will function normally if there is no underlying dementia. Even if the patient remains demented, the antidepressant may be continued as effective symptomatic therapy.

Drug toxicity must be at the back of every physician's mind when he sees a demented patient. It is wise to stop all but the most necessary medications, and to consider those left as possible causes of the dementia. For example, consider reducing the dose of digoxin in a 90-year-old patient from 0.25 mg to 0.125 mg daily. Always question the relationship between dementia and the use of psychotropic agents. L-dopa for Parkinsonism is frequently associated with dementia. Every drug must be considered a possible cause of dementia.

Table 3 describes the pathological changes, gross and microscopic, in SDAT. Most of this work has been done by Terry and his coworkers[5,6,7] at the Albert Einstein College of Medicine in New York. The loss of neurons and resulting cerebral atrophy are strikingly illustrated by Figure 1, where one may note marked increase in the sulci, increase in the size of the lateral ventricle, and decrease in the quantity of both gray and white matter. These findings are also the typical findings of the computerized tomographic (CT) scan as shown in Figure 2, where enlargement of the ventricles and widening of the sulci are prominent.

The most characteristic microscopic finding of SDAT is the neurofibrillary tangle. The neurofibrillary tangle is composed of bundles of

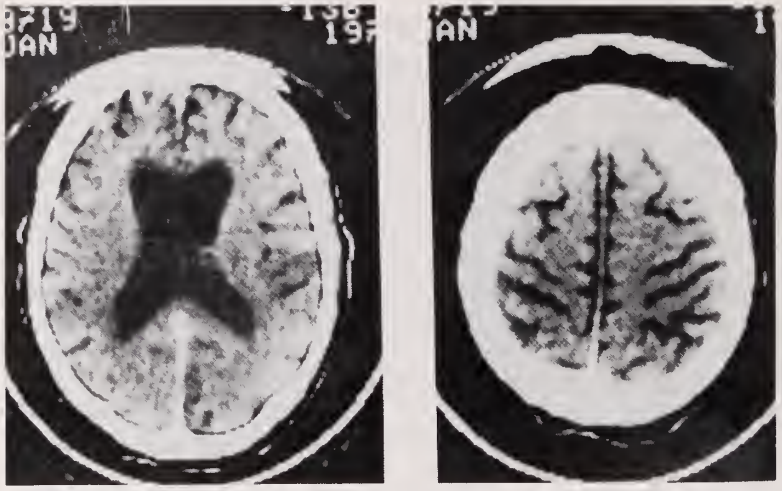

FIGURE 2—Cerebral atrophy. There is dilatation of the ventricles and sulci (printed by permission[13]).

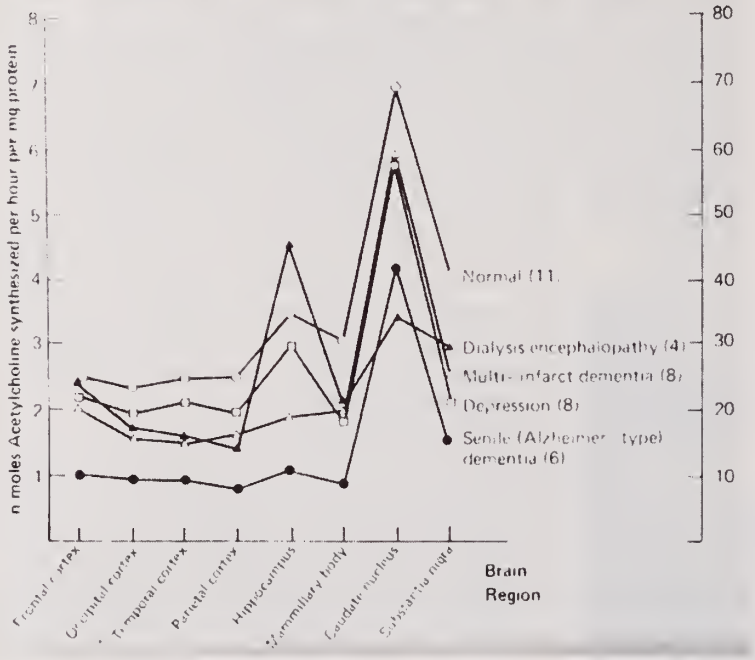

FIGURE 3—Choline acetyltransferase activities in normal (hospital inpatients), demented and depressed subjects in eight brain regions. Each point represents the mean (the number of cases is shown in parentheses).

paired helical filaments in the neuronal cytoplasm. Paired helical filaments are found in a number of conditions characterized by dementia including Pick's disease, postencephalitic Parkinsonism, Down's syndrome, and subacute sclerosing panencephalitis, demonstrating that these findings are not specific for SDAT. Terry and his workers have begun preliminary studies of the molecular characteristics of paired helical filaments, and have shown that they are primarily composed of the protein β-tubulin of MW 53,000, a cleavage product of the primary neurotubule protein, tubulin.

Senile plaques are the second microscopic finding common in dementia. Tomlinson[4] found that the average number of plaques in demented patients per high-power field was 14.7 whereas normal age-matched controls had 3.3.

Immunologic, viral, and biochemical factors have been considered as possible elements in etiology of SDAT. Although it seems unlikely that SDAT will turn out to be primarily an autoimmune disease, Nandy[8] has demonstrated the presence of brain reactive antibodies in mice and has shown that damaging the blood brain barrier will result in increased quantities of demonstrable brain reactive antibodies.

A viral etiology also does not seem likely at this point, even though there are several dementias that are associated with viral infection. Creutzfeldt-Jakob disease, the rapidly dementing illness of middle-aged men and women associated with ataxia, myoclonus, and characteristic electroencephalographic findings, is felt to be due to a slow virus, although the virus has not yet been isolated from this transmissible disease.

The most promising work in etiology of SDAT is in the field of biochemical studies[9] where studies of the neutrotransmitter enzymes, glutamic acid decarboxylase and choline acetyltransferase (Fig 3), have revealed significant reductions in all parts of the brains of patients with SDAT. There have been attempts to treat these demonstrated decreases in neurotransmitter enzymes by adding substances such as choline, but as yet there has been no marked clinical response.[10]

In the past it has been felt that aluminum might be an etiologic factor in SDAT, but recent studies[11] reveal that there is a gradual increase in the aluminum content in the brain as one gets older. The values found in SDAT patients are almost identical with those found in age-matched controls.

Considering our lack of knowledge of the pathophysiology of senile dementia, Alzheimer-type, it is no wonder that the present treatment is inadequate. The use of psychotropic agents is more frequently helpful to the attending personnel in institutions than it is to the unfortunate patient. There is no evidence that the level of dementia has improved with such treatment. Probably the most effective way to manage SDAT is by means of a sophisticated program of therapeutic recreation in which socialization and interaction between patients and personnel is stressed. Such an approach seems most satisfying to patient, family, and professional personnel caring for the patient, although it cannot be expected to affect the underlying disease process. Programs of reality orientation, resocialization, remotivation, attitude therapy, and reinforcement therapy are all based on increasing the interaction between the demented patient and staff, family, and friends. Milieu therapy is another social approach to treatment of dementia. It assumes the whole social environment is the treatment modality and requires the development of a "therapeutic community."[12]

Summary. Senile dementia, Alzheimer-type is a major illness of the elderly, responsible for an enormous amount of suffering and one which is poorly understood by physicians. It is important to differentiate this illness from treatable causes of dementia. It is important that physicians be able to explain to families that dementia is not usually due to hardening of the arteries and is not part of the normal aging process, but is probably a biochemical abnormality which someday may have a satisfactory therapy.

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Abstracts

Lyme arthritis in Wisconsin

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Lyme arthritis was thought to be restricted to New England but three cases were recorded in patients who were campers in a tick infested woodland of northwest Wisconsin near Sarona. The disease is characterized by a rash, severe constitutional symptoms, and arthritis. This was characteristic of the clinical features consistent with lyme arthritis.

The article emphasized first, that the lyme arthritis can occur in an area outside the limited region of coastal New England. Also, that the first reported case in the United States of erythema chronicum migrans was identified in north central Wisconsin at Medford, only 160 km from Sarona. This report confirms the association between the clinical syndrome of lyme arthritis and the antecedent tick bites. Also, each of the patients displayed severe systemic illness at the onset and had initial diagnosis of meningitis or meningoencephalitis. The arthritis was absent in the early phases but became prominent after the systemic manifestations had resolved.

The authors emphasized that early diagnosis is based on the characteristic skin lesion of erythema chronicum migrans. The findings confirm the observation that early systemic manifestations are self-limiting and that the recurrent episodes of arthritis tend to be milder with time.—VSF ■

REFER TO: Hardie GH, Stein G, CoBabe T: Gastric bypass: A safe, effective procedure? *Wisconsin Med J* 78:34-38 (Nov) 1979

KEY WORDS: Gastric bypass, morbid obesity

Gastric bypass: A safe, effective procedure?

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ALTERATION OF gastrointestinal anatomy has been under investigation for control of morbid obesity since the late 1950s. In 1963 Payne and Associates[1] described their experience with jejunocolic shunts which were taken down when the desired weight was accomplished or when sufficiently adverse side effects developed. In 1969 they[2] described a technique of jejunoileal bypass which consisted of 14 inches of jejunum being affixed to the side of the ileum four inches proximal to the ileocecal valve. This procedure was designed as a permanent arrangement, but over the years it has been found to be complicated by many problems including diarrhea, hemorrhoids, hypokalemia, cholelithiasis, nephrolithiasis, arthritis, liver failure, and other metabolic disorders. In 1967 Mason[3] described his experience with gastric bypass. A comparison of the two procedures was described by Alden[4] in 1977. In this study he concluded that the weight loss using the two techniques was approximately the same, but the morbidity of the gastric bypass was far less than that of the jejunoileal bypass.

Jejunoileal bypass was done by the author seven times between 1970 and 1975 (Table 1). In this small sample the average preoperative weight was 327 lb, or 148 kg, and the average weight loss was 101 lb, or 46 kg. The average postoperative stay in the hospital was 8.5 days. There were multiple metabolic and gastrointestinal symptoms; only two of the seven patients evaluated the procedure as good. Over the years all but two of the small bowel bypass cases have been taken down or taken down and converted to gastric bypass. All of the jejunoileal bypass patients whom we have taken down both from our own sample and from others have been largely relieved of their presenting complaints and have been imminently more satisfied with the second procedure.

Gastric bypass for obesity has proved for us to be a safe, effective procedure with low morbidity. Our experience with this procedure has been in marked contrast to our prior experience with jejunoileal bypass. Our gastric bypass experience has been much more vast (Table 2). Between January 1977 and January 1979 we did 120 of these procedures with an average preoperative weight of 281 lb, or 128 kg. Our average postoperative stay in the first group of 40 patients was 5.7 days and the second group of 40 patients was 3.8 days, with the last group of 40 patients being only 2.8 days. Our average weight loss has been 8% of the preoperative weight at the end of the first month, 17% of preoperative weight at three months postoperatively, and 24% of preoperative weight loss at six months postoperatively. Our average weight loss at the end of one year is presently 36%. However, at this time the number of cases followed for a year is not large enough to be statistically significant.

Psychosocial evaluation. Psychosocial problems with obesity and its control have been recognized. Although Abram,[5] Solow,[7] and others have described increased levels of personal adjustment as a result of bypass operation and subsequent weight loss, other studies including Solow,[7] Castelvuovo-Tedesco,[6] and Neill[8] note increase of marital discord and subsequent divorce associated with this phenomenon. In consideration of this the Social Service Department of Theda Clark Regional Medical Center has agreed to be involved in this study by completing pre- and postoperative evaluations of 50 consecutive patients admitted between August 1978 and January 1979.

The preoperative evaluation consisted of the completion of a social history questionnaire, psychological testing with the Minnesota Multiphasic Personality Inventory (MMPI) and a personal interview. While a complete statistical analysis of these data has not yet been completed, it is noted from the social questionnaire and interview that marital problems exist in 11 cases, two patients have spouses with depression and alcoholism, and 25 patients have significant personal problems themselves. Computerized MMPI

Publication support provided. Reprint requests to: Gordon H Hardie, MD, Surgical Associates of Neenah, SC, 169 E North Water St, Neenah, Wis 54956. (715/725-4527) Copyright 1979 by the State Medical Society of Wisconsin.

profiles indicate 24 patients with significant personal problems and 10 are recommended for psychiatric interview. The changes in the personal and marital adjustment of these 50 patients which take place during the 12 months following the bypass operation will be the subject of a subsequent report.

Procedure. Our patients are all admitted to the hospital 24 hours early, and in addition to the routine laboratory studies they have an upper gastrointestinal series and a gallbladder x-ray film if their gallbladders are present. Also electrocardiographic, arterial blood gases, and thyroid function studies are obtained. They are seen by the Respiratory Therapy Department and instructed in the use of the incentive spirometer and the use of the intermittent positive pressure breathing machine which will be used during the first 24 to 48 hours postoperatively. Patients are given a clear liquid diet and routine bowel prep on the day before their operation which includes a 1.0 gm of neomycin and 250 mg of erythromycin at 1:00, 2:00, 4:00 and 8:00 PM with 2 ounces of castor oil at 6:00 PM. Prochlorperazine (Compazine®), 10 mg, is given at noon to control nausea often associated with the antibiotic therapy. They are all carefully instructed in the very judicious use of narcotics and in simple exercises for their calf muscles in the postoperative period.

Our operative procedure (Fig 1) consists of an upper midline abdominal incision. After exploring the abdomen the stomach is then freed from approximately the 50% point on the greater curvature from the omentum and spleen all the way to the esophagogastric junction. The ligate-divide staple instrument (LDS) is used initially; and after the costal margin is crossed, large metal surgical clips (Ligaclips®) are used on the omental side and suture ligatures on the gastric side. As the lesser gastric space develops, packs are placed on the pancreas and left side of the abdomen for retraction. Dissection is carried proximally very carefully as the spleen is encountered.

Approximately one and a half finger breadths distal to the esophagogastric junction in a thin place in the lesser omentum a defect is created and a row of staples is placed across the stomach with the thoracoabdominal 90 instrument (TA90), separating the proximal 5-10% from the distal 90-95%. To accomplish the placement of the instrument the left forefinger is placed through the defect in the lesser omentum and the TA90 is led over the stomach with the jaws of the instrument facing the liver. Following the placement of the staple line the ligament of Treitz is identified and a loop of jejunum is brought over the colon after sweeping the omentum into the right side of the abdomen, and an anastomosis is done between the proximal pouch and the proximal jejunum as shown using the gastrointestinal anastamosis instrument (GIA) at approximately 2.0 cm on its marker. The stab wounds are closed in a routine fashion and at completion of the anastomosis the thumb tip is just admitted.

The Salem tube which is placed in the stomach after the induction of anesthesia is removed two hours postoperatively. On the day following the operation the patient is started on a clear liquid diet and on the second postoperative day on a bland diet. They are instructed in a bland diet on the first or second postoperative day and are discharged if they are afebrile and feel able on the second or third postoperative day. The occasional patient is now going home on his/her first postoperative day. These patients are instructed to

Table 1—Jejunoileal bypass
7 Patients: 1970-1975

Average age	32 years
Average weight	327 lb (148 kg)
Average weight loss	101 lb (46 kg)
Average postoperative stay	8.5 days

2 patients rate result as good

Table 3—Gastric bypass

Mortality	0%
Morbidity	2.5%
Splenectomy	1.7%

99% patients rate result EXCELLENT

Table 2—Gastric bypass; 120 patients: 1977-1979

Cases	Av Age	Preop Av Wt	Av Postop Stay-Days	Av Wt Loss (Mos)			
				1	3	6	12
1-40	33	289	5.7	8%	17%	23%	35%
41-80	37	273	3.8	8%	16%	25%	
81-120	38	281	2.8	9%			

Males: 10% Females: 90%

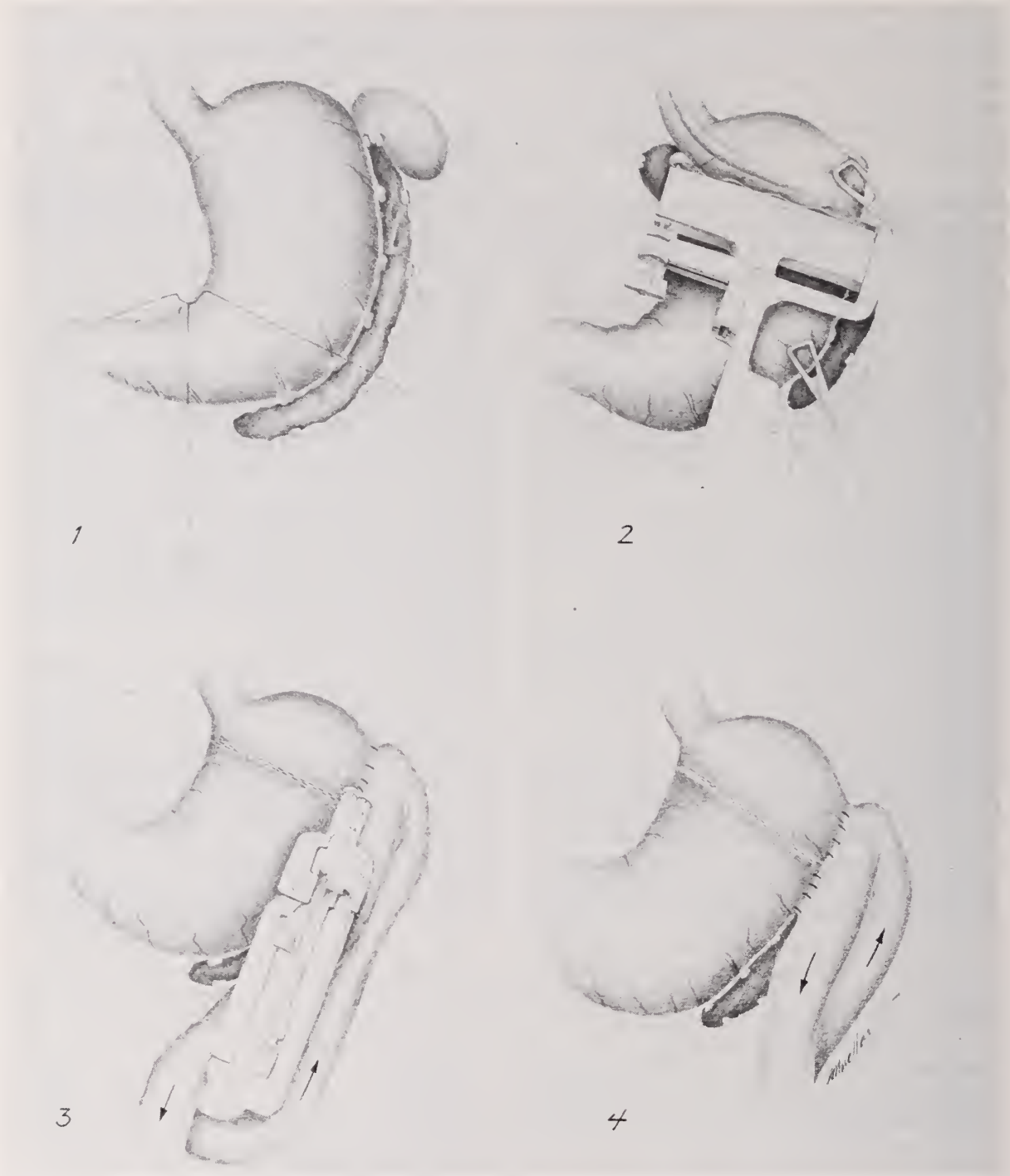

FIGURE 1—Gastric bypass procedure.

remain on a low calorie bland diet for two weeks and then on a low calorie general diet eating slowly, chewing their food well, and taking a multivitamin with minerals daily for at least the first six months. Antibiotics are given intravenously in the postoperative period until the IVs are discontinued: cefoxitin sodium (Mefoxin®), at present, 1.0 gm every six hours.

Additional operative procedures are usually avoided in conjunction with a gastric bypass. If an umbilical hernia is present, this is usually repaired from inside the abdomen. Occasionally a tubal ligation, on request, is accomplished; but other elective procedures are avoided except under extenuating circumstances. Even the presence of gallstones is overlooked with the patient being instructed that at a subsequent date, after satisfactory weight loss, an interval cholecystectomy

would be indicated. Six patients had cholecystectomy in conjunction with their bypass and each of these patients had a slightly prolonged postoperative convalescence suggesting to us that the margins of safety were being pushed by adding this procedure.

Morbidity. Postoperative morbidity has been minimal (Table 3). Early in our series we had two patients who had difficulty which we felt was due to construction of the gastrojejunostomy in a retrocolic or retroomental fashion. In both of these cases it was felt that either the heavy omentum and/or the heavy transverse mesocolon dragged downward on the anastomosis partially occluding the outflow tract from the stomach creating our problems which in the first case consisted of obstruction of the afferent loop and perforation of the distal stomach incident to the obstruction. In the second case a narrowing of the anastomosis was felt to be due to the same cause and had to be corrected with a secondary procedure as did the first complication mentioned. Our third complication was a postoperative wound dehiscence after discharge from the hospital on the 8th postoperative day. This was a 56-year-old, 460-lb male who, of course, was readmitted for repair of his dehiscence and surprisingly enough requested and was granted discharge on his 4th postoperative dehiscence repair day. As mentioned two splenectomies have been necessitated in the intraoperative period. Since there have been no adverse effects from this procedure, these cases have not been included in our morbidity statistics; but they are separately itemized in Table 3 showing an incidence to date of 1.7%.

Results. The results of the procedure have been most gratifying. In virtually 100% of cases the patients have invariably reported, within a few days, a feeling of elation and increased energy. It may well be due to the lack of gorging of the gastrointestinal tract.

Most typically the patients continue to feel well during the postoperative period, almost immediately increasing their level of activity. Those that are able to resume jobs that do not entail heavy lifting are allowed to do so at three weeks postoperatively; and almost without exception, at one month postoperatively, all patients report extreme satisfaction with their feeling of well-being and weight loss.

Hypertensive patients on medication have not had their medication resumed postoperatively unless it is deemed advisable at the time of their one-month, postoperative visit which is rare.

Adult onset, insulin dependent diabetics are found to have their insulin requirements reduced by approximately one-third to one-half in the immediate postoperative period. They are carefully instructed in the gradual reduction of their insulin dosage depending upon their ability to keep their urine spill of sugar at 2+ or below. All of our adult onset, insulin dependent diabetic patients, which number six at present, have been able to discontinue the use of insulin between the second and third months postoperatively. Recently one patient being given 20 units of NPH daily preoperatively was able to discontinue the use of insulin at the end of her first month postoperatively. We have not operated on any juvenile diabetics to date.

We have not found any problem with operating on patients as old as 64 years. In fact, when we study the nine patients whom we have operated on over the age of 50, we find that their average postoperative weights and postoperative stays, and in general their entire course, have not been particularly divergent from the group as a whole (Table 4).

The patient in our over- age-50 group who had a prolonged convalescence was a 61-year-old, 5 ft 6 in, 330-lb male. He was admitted to the hospital on the medical service with congestive failure, chronic obstructive lung disease, and marginal renal function. All three of these organ systems remained partially decompensated during the

Table 4—Patients over age 50

	Age	Sex	Postop Days	Preop Wt	Av Wt Loss (Mos) lb	1	%	lb	3	%	lb	6	%
1	52	M	5	288	24		8%	37		14%	71		25%
2	56	F	3	234	13		6%	31		13%			
3	64	F	4	312	21		7%	40		13%			
4	61	M	22	317	39		12%						
5	52	F	3	248	19		8%						
6	·57	F	4	394	27		7%						
7	55	F	3	253	26		10%						
8	52	F	3	259	35		14%						
9	56	M	2	460	44		10%						
	Average		5.4*	307	27		9%	*3.4 s #4					

early postoperative convalescence necessitating a stay of 22 days following the operative procedure with intensive support from consultants in cardiology, respiratory physiology, and nephrology. He has lost 50 lb, or 15%, of his preoperative weight and has stabilized at approximately 280 lb. The symptoms of his marginal organ system functions have disappeared, and he is not at all interested in further efforts at weight reduction. He states to the effect that he does not mind at all being heavy, loves to eat, and intends to continue to do so. The extenuating medical circumstances and the benefit derived would suggest that the procedure was worthwhile, but this does demonstrate a case of poor patient motivation and selection.

Discussion. All of our patients prior to operation are instructed extensively in the nature of the operation and their personal goals in undergoing it. Patients who are not personally committed to a change in their body shape and their life style are instructed not to have the operation. This includes patients who have come for evaluation of the procedure only under duress from their spouse, physician, family, or society and who do not exhibit a strong personal desire to alter their obesity. They are all carefully instructed that the operation only facilitates a reduction of their caloric intake and they are strongly urged to satisfy as many of their caloric needs as possible from the tremendous stores of caloric energy that have been housed about their body in excess fat. We attempt to make them fully understand that they will lose weight on a 1000-calorie diet just as fast before the operation as they will after the operation. The operation is of primary benefit to the patients as they have easily sated hunger following the procedure and should find it, therefore, much easier to adhere to a very restricted calorie intake.

Summary. We have found gastric bypass for control of morbid obesity to be a very satisfactory procedure with no mortality and very low morbidity in the patients selected to date. The procedure is most effective in those patients who are truly committed to freeing themselves of their obesity and changing their eating habits but who are finding it impossible to obtain this goal by dieting because of the massive amount of weight they have to lose and the prolonged discomfort from hunger that would be necessitated to obtain this goal. We are finding that those patients who do not mind their obesity and are not particularly interested in changing their eating habits are able to abort the benefits of the operation at approximately 15-20% weight loss which is probably not sufficient weight loss to warrant this procedure.

This is a preliminary report, and we are planning on presenting further our experience at a later date and after the medical and psychosocial aspects have been evaluated at an appropriate interval.

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Abstracts

Airway response to hair spray in normal subjects and subjects with hyperreactive airways

DONALD P SCHLEUTER, MD; RICARDO J SOTO, PhD; EDWARD D BARETTA, MS; ANTHONY A HERRMANN, MD; LEE E OSTRANDER, PhD; and RICHARD D STEWART, MD, Milwaukee, Wis:

Chest 75:544-548 (May) 1979

Short-term 20-second exposure to hair sprays A and B failed to show significant decreases in maximum expiratory flow rates at low pulmonary volumes in normal subjects; however, significant decreases were observed with hair spray B in eight subjects with hyperreactive airways (abnormal response to inhalation of methacholine). On the partial flow-volume curves, flows at 40% and 25% of forced vital capacity decreased 8.9% to 10.3% and 14% to 18.7%, respectively. The hair sprays differed in their content of perfume and plasticizer, and since the latter is generally considered nontoxic at room temperature, the perfume may be the responsible agent. It would appear that normal healthy individuals are at little risk, at least from brief exposure to hair spray; however, in the presence of hyperreactive airways, as seen in asthmatic subjects and in some people with allergic rhinitis and viral respiratory infections, an immediate response of the airways may result from exposure to some hair sprays. ■

REFER TO: Hansotia PL: Understanding pain — the endorphins and the gate control theory. *Wisconsin Med J* 78:39-42 (Nov) 1979

KEY WORDS: Pain, endorphins, opiate receptors, neurologic dysfunctions

Understanding pain: The endorphins and the gate control theory

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PAIN IS THE MOST COMMON symptom prompting an individual to seek medical help. Much of the anatomy, physiology, and biochemistry of pain has remained obscure despite the considerable growth of information in this field. When confronted by a clinical situation involving pain, physicians must discover and treat the cause and also treat the symptom. Whereas our skills in effectively dealing with the former have proceeded along rational and predictable lines, our efforts in the latter have been largely empirical. The anatomical substrate of pain perception, recognition, and transmission are in a state of some controversy and confusion at the present. The biochemical substrate of pain, of which the opiate receptors and the endorphins* are becoming an increasingly prominent part, and the neurological circuitry along which it travels, will form the main body of this discussion. Numerous articles have appeared in recent years reviewing various aspects of this subject[1,2,3] This review attempts to simplify and clarify this subject for the practicing clinician.

Pain receptors (nociceptors) are generally thought to be the free nerve endings of small myelinated and unmyelinated fibers. These nociceptors are stimulated either by strong mechanical deformation or by extremes of hot or cold temperatures. Chemoreception occurs when tissue damage from mechanical or thermal injury liberates extracellular chemical substances which lower the firing threshold of the mechano- and thermoreceptors so that previously innocuous mechanical or thermal stimuli produce pain. Substances liberated by tissue damage which lower the threshold of pain receptors include potassium, acetylcholine, histamine, serotonin, prostaglandins and bradykinin.[1] The nociceptors are connected to two sets of peripheral fibers that mediate pain sensation: Small (6 micron) thinly myelinated A delta fibers which conduct about 35 meters per second and unmyelinated C fibers (1 to 2 micron) which conduct at about 0.5 meters per second. This dual set of fibers explains the phenomenon of "double pain." A noxious stimulus elicits first a sharp prickly well-localized pain, mediated by the more rapidly conducting A fibers; and the C fibers mediate a burning, poorly localized, exceedingly unpleasant "second pain."

All primary sensory afferents have their cell bodies in the dorsal root ganglion. Nociceptor fibers enter the cord, then ascend or descend for one or two segments at the medial portion of Lissauer's tract to enter the more ventrally placed dorsal horn. The dorsal horn consists of six laminae, with lamina 1 being the most dorsal. Interaction between neurons in the dorsal horn is an important site for modulating sensory input. These interactions in the substantia gelatinosa of the dorsal horn are the subject of Melzack and Wall's gate theory of pain,[4] which although controversial, is probably the most widely accepted at the present. A reappraisal and restatement of this theory was recently published by Wall.[5]

Melzack and Wall[3] proposed that pain is conducted by "first central transmission" or T cells which, when fired, trigger an action system that leads to the perception of pain. The T cells are stimulated by both large myelinated fibers (which conduct nonpainful sensation) and small fibers (which conduct painful sensations). Both large and small fibers synapsing on T cells are presynaptically inhibited by cells from the substantia gelatinosa. These cells from the substantia gelantinosa are activated by large fibers and inhibited by small fibers. Thus, a large fiber barrage activates cells in the substantia gelatinosa which in turn inhibits large and small fibers from stimulating T cells. No pain is perceived. A small fiber barrage inhibits cells in the substantia gelatinosa, the result being no inhibition of incoming large and small fibers to the T cells, leaving the "gate" open for perception of pain. Descending fibers from cerebral cortex or lower structures (*eg;* midbrain) might also modulate this system (Figs 1 and 2).

This hypothesis has several clinical implications: Diseases which selectively damage large fibers (namely herpes zoster) might produce

*Endorphins are endogenously produced polypeptides made by nerve cells in certain areas of the brain and that have morphine-like qualities.

Publication support provided. Reprint requests to: Phiroze L Hansotia, MD, Dept of Neurology, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449. Copyright 1979 by the State Medical Society of Wisconsin.

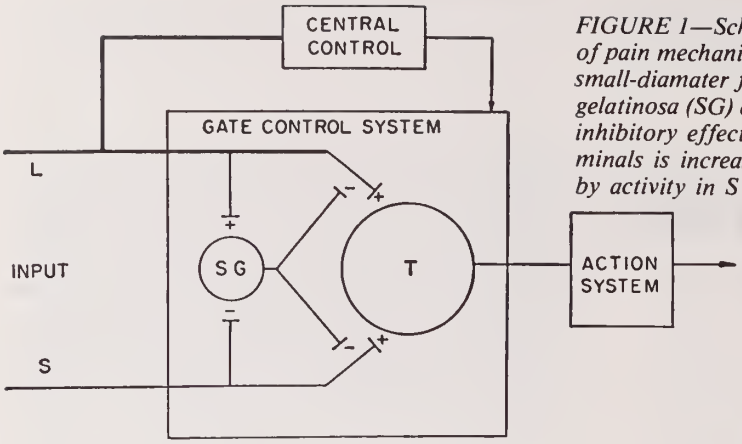

FIGURE 1—Schematic diagram of the gate control theory of pain mechanisms: (L), the large-diameter fibers; (S), the small-diamater fibers. The fibers project to the substantia gelatinosa (SG) and first central transmission (T) cells. The inhibitory effect exerted by SG on the afferent fiber terminals is increased by activity in L fibers and decreased by activity in S fibers. The central control trigger is represented by a line running from the large-fiber system to the central control mechanisms; these mechanisms, in turn, project back to the entry cells of the action system. (+), excitation; (-), inhibition (see text).

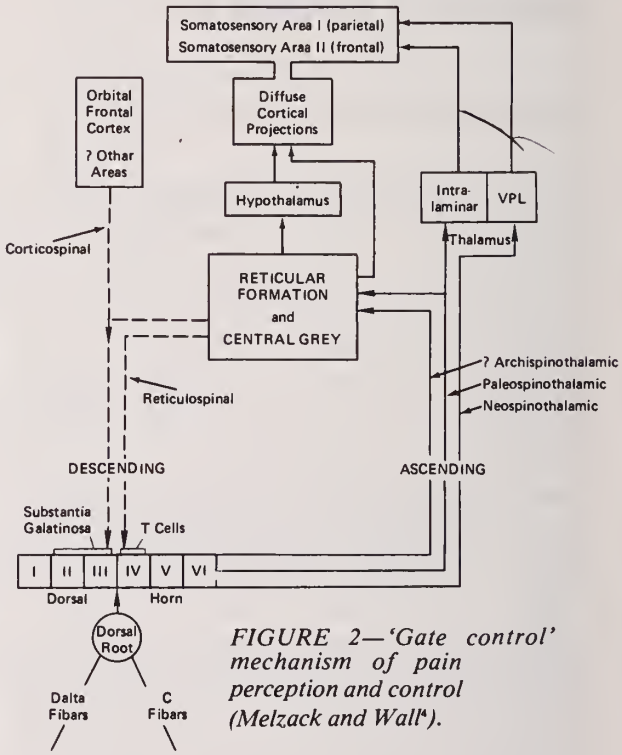

FIGURE 2—'Gate control' mechanism of pain perception and control (Melzack and Wall[4]).

chronic pain by leaving the gate open; techniques which selectively stimulate large fibers (namely cutaneous stimulators, vibrators, or simply rubbing an area) might relieve pain by closing the gate. Both the theory and its implications have been questioned on physiological and clinical grounds, but it continues to remain a useful way of thinking about interactions in the nervous system.

Fibers originating in the brain-stem reticular formation receiving input from several sources, including the paleospinothalamic and archispinallemniscal pathways, ascend in polysynaptic projection to wide areas of the thalamus, including the intralaminar nuclei and the ventral posteral lateral (VPL) nucleus. The anatomy and physiology of the reticular formation is becoming increasingly important in our understanding of pain perception since recent evidence suggests that electrical stimulation of this area produces analgesia and that the site of action of narcotic drugs is largely here.

The most exciting new developments in the field of nociception have been discoveries concerning the opiate receptor[2] and endogenously produced substances which appear to bind this receptor.[6] A stereo-specific receptor for narcotics possibly related to cerebroside sulfate has been isolated from brain. The receptor exists in highest concentrations in brain-stem reticular formation and the limbic system, the areas where narcotic analgesics are believed to work. The receptor binds both narcotic agonists and antagonists. In addition, two endogenous substances have been identified in brain which also bind to these receptors. One, the endogenous "ligand," also called enkephalin or morphine-like factor as a water-soluble, heat-stable factor with a molecular weight of about 1000, which competes with narcotics for the stereo-specific opiate receptor. Another peptide-like substance called pituitary opiate peptide has been extracted from the pituitary gland and appears to differ from enkephalin in that it has a molecular weight between 1500 and 2000 and is destroyed by both trypsin and chymotrypsin. The highest concentrations of both substances are in the same area as the opiate receptor; namely, the periventricular and periaqueductal gray areas. These substances have morphine-like qualities, bind to the opiate receptor, and can be displaced by opiate antagonists. These substances are currently the focus of much investigation[6,7] and lend hope to the possibility that natural analgesic drugs may eventually be developed.

With a simple, specific, and sensitive opiate receptor assay, Snyder, et al[2] were able to answer important questions about how opiates act. Opiates do not alter sensory threshold directly. Instead, they seem to affect the motivational affective component of pain. When treated with morphine, patients say they can still feel the pain but it just doesn't matter. Patients who have experien-

ced a frontal lobotomy react to painful sensations very similarly.

A number of brain regions have been implicated in the perception of pain. Major ones are the rapidly conducting primary sensory pathways and the multisynaptic, slowly conducting, medially located paleospinothalamic and spinoreticular pathways. The latter involve areas of the brain such as the periaqueductal gray and the medial nuclear thalamus, and the hypothalamus and other regions of the limbic system. These are also areas rich in opiate receptors.

Most brain biochemicals are distributed rather uniformly throughout the brain. The striking heterogeneity of opiate receptor distribution is reminiscent of the large regional differences for concentrations of neurotransmitters. There are similarities of opiate receptor distribution to the distribution of several neurotransmitters, such as acetylcholine, gamma-aminobutyric acid (GABA), serotonin, and the catecholamines; however, there are differences as well. For example, serotonin is rich in the caudate nucleus, hypothalamus and medulla, as is the opiate receptor. The mid-brain raphe area, which contains the cell bodies of serotonin neurons in the brain, is one of the areas richest in serotonin content but is quite poor in opiate receptor binding. Opiate receptor distribution corresponds fairly closely to the paleopinothalamic and spinoreticular pathways and mediates motivational-affective components of pain.

It is currently felt that all mammals possess a set of powerful and endogenous centrifugal mechanisms of pain control. Such endogenous modulation of pain has been considered in the past and postulated in the gate control theory of pain. Indirect evidence for such mechanisms comes from several observations. Analgesia or clinical pain relief can be produced by various stimuli: Acupuncture, "counter-irritation" with chemicals, extreme temperatures or pressure, or with electrical stimulation. It may be suggested that these responses are due to activation of endogenous antinociceptive processes. The function of the enkephalin neurons is probably modulatory as suggested for the short enkephalin (inter) neurons in the dorsal horn of the spinal cord. These neurons seem to form axoaxonic synapses with primary afferent fibers probably involved in the conduction of pain.

Nociception under normal physiological conditions is necessary for defensive reactions. In pathological conditions where pain is not felt (congenital analgesia) it represents a serious disorder. Chronic pathological pain, on the other hand is without apparent cause, yet it causes the patient severe suffering. The cause of chronic intractable pain is often attributed to an organic lesion in peripheral nerves. The patient is then capable of localizing the painful area and can also describe his pain reaction accurately. In other patients, the localization of pain may be less discrete, the patients may be depressed and it seems obvious that pain is a manifestation of psychic disturbance rather than a primary somatosensory experience. In an attempt to analyze the influence of etiologic factors in chronic pain, lumbar cerebrospinal (CSF) fluid samples have been analyzed for the levels of endorphins. Terenius[8] in a pilot investigation observed that cases with severe chronic pain of organic origin (trigeminal neuralgia) showed lower levels of the endorphin fraction in spinal fluid. In cases of diffuse psychogenic pain, where pain should rather be considered as a symptom, the levels of endorphin may be normal or supernormal. With an increasing depressive component, CSF endorphin levels increase and may reach very high levels, particularly in cases of endogenous depression where pain may or may not be a prominent symptom.

A classical approach to the study of physiological process is to investigate pathological conditions where dysfunction of the process can be anticipated. The results of endorphin measurements in patients with severe chronic pain of organic origin suggests that the endorphin systems are poorly active in this condition. Supernormal activity, on the other hand, is observed in the depressive stage. The main importance of these observations lies in the fact that deviations from normal exist in pathological situations. The cause or relationships may be more difficult to define. Essentially two explanations can be offered to account for the low endorphin levels in chronic pain. The first possibility is that pain, itself, causes a general depression of endorphin activity. If this is the case, a general hypersensitivity to noxious stimuli should be expected in the patient, a situation which has, in fact, been described. The second possibility is that the local pain is caused by local deficiency in the endorphin system, a possibility which seems less probable since it would not be expected to show up as a decrease in total endorphin activity.

It is well known that pain relief to a clinically significant extent can be induced by electrical stimulation, but the underlying basic mechanisms have not yet been investigated. Animal experiments would favor the hypothesis that in both intracerebral and peripheral stimulation mechanisms, activation of pain modulatory systems at the spinal and spinal trigeminal level are important. It is, therefore, of interest that elevation of lumbar CSF endorphins can be observed under both these conditions. Furthermore, naloxone-reversibility (opiate antagonists) is observed, strengthening the hypothesis that activation of endorphin mechanisms is involved.

This brings us back to the question of the physiological importance of endorphins in the regulation of pain. If several parallel modulatory systems exist, pain modulation will be a function of the concerted action of the whole set of modulators. Blockade of one system, such as the endorphin system, may not reach an easily observable extent because of the compensatory action of other systems. Definition of the exact role of endorphins in various situations requires further observation and investigation. To the clinician these concepts are of value not only in the basic understanding of the phenomenon of pain and of the various types of pain but also in an appropriate grasp of the newer developing technologies that are being applied for the relief of this problem. Although these developments generally inspire optimism, it must be remembered that the newer technology remains to be firmly substantiated by careful testing and confirmed among medicine's therapeutic armamentarium by the trials of time.

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Abstracts

Effect of immediate and delayed cold immersion on burn edema formation and resorption

ROBERT H DEMLING, MD; RICHARD B MAZESS, PhD: WILLIAM WOLBERG, MD, University of Wisconsin Hospitals, Madison, Wis: *J Trauma* 19:56-60 (Jan) 1979

Massive wound edema after a burn may impair healing and help to convert partial to full thickness injury. Cold treatment (usually by immersion) has been reported to decrease wound edema and is useful in first-aid treatment of burns. Since cold by decreasing peripheral blood flow could actually be harmful to a deep burn, especially if applied late, the effect of cold immediately and two minutes postburn on edema formation and resorption in a deep second-degree burn was measured in sheep hindlimbs. Immediate application of cold by immersion in 15 C saline for 30 minutes reduced the edema of a deep second-degree burn and did not impair resorption rate compared with control limbs, fluid content returning to baseline after one week. Cold treatment beginning two minutes after the burn did not decrease edema formation and did impair resorption; 15% of the edema fluid was still present one week postburn, suggesting further injury to the burn wound vasculature with use of cold immersion two minutes postburn. ■

Intravenous therapy with terbutaline

S ROGER HIRSCH, MD, Medical College of Wisconsin and Veterans Administration Center, Milwaukee, Wis: *Chest* 75:648 (May) 1979

Intravenous administration of β-adrenergic agonists in the treatment of life-threatening status asthmaticus has been reported previously. A major untoward reaction to therapy with these drugs is the occurrence of cardiac arrhythmias, particularly in the presence of hypoxemia. However, newer β-adrenergic agonists such as terbutaline have less cardiac stimulating effects for a given bronchodilating effect. Terbutaline sulfate was administered intravenously to a patient who appeared to be moribund from status asthmaticus, with a remarkably salutary effect.

The patient had over-treated herself with a hand-held bronchodilator-containing inhaler and became comatose after being given a barbiturate. Although the patient received a large dose of succinylcholine, which was apparently life-saving, the degree of relief was not sufficient to allow continued adequate ventilation. Relief of the bronchospasm after intravenous therapy with terbutaline was so rapid and striking that its effect was not likely to be misinterpreted. ■

REFER TO: Curet LB: Determination of gestational age. *Wisconsin Med J* 78:43-44 (Nov) 1979

KEY WORDS: Gestational age, pregnancy management

Perinatology

Editor: **LUIS B CURET, MD**
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Determination of gestational age

Luis B Curet, MD, Madison, Wisconsin

EDITORIAL NOTE: One of the most common problems encountered at a referral maternity center is the patient with an unreliable gestational age late in the course of her pregnancy. Because of the problems of post datism, intrauterine growth retardation, and premature labor, it is crucial to accurately date pregnancies in patients who have an unreliable gestational age. The following article outlines the management of such patients.

IT IS CUSTOMARY to date a pregnancy by the number of weeks from the first day of the last menstrual period. This estimation is fairly reliable in women who have regular monthly menstrual cycles, have not been on oral contraceptives shortly before conceiving, remember accurately the date of their last normal menstrual period, and have not bled since that period. Even in such women, however, the estimate of gestational age can be in error by as much as two to three weeks. Obviously the error is much greater in women who do not meet *all* of these criteria.

Because methods to estimate gestational age are quite unreliable late in pregnancy, it is of the utmost importance that patients with questionable or unreliable "dates" be identified early in pregnancy. Estimation of gestational age by clinical landmarks and ultrasound examination is most accurate when begun early and based on multiple observations.

At the University of Wisconsin Perinatal Center at Madison General Hospital we follow the following protocol to estimate gestational age:

(1) If a patient gives a history of regular menstrual cycles, has not used birth control pills for at least three months prior to conception, remembers the first day of her last menstrual period, and has not bled after her last period, she is considered to have reliable dates and her gestational age will be dated by the number of weeks since the first day of the last menstrual period.

(2) The following will be considered to have unreliable dates:
   (a) Patients with a history of irregular (or nonmonthly) cycles.
   (b) Patients who have taken oral contraceptives within three months of conception.
   (c) Patients who do not remember the first day of the last normal menstrual cycle.
   (d) Patients who have some vaginal bleeding following their last normal period.
   (e) Patients whose last menstrual period was not normal.
   (f) Patients who conceived while nursing.
   (g) Patients whose uterine size does not correlate to the assigned gestational age.

In order to determine gestational age in these patients with reasonable accuracy we recommend the following:

(1) Pregnancy tests should be done as early as possible. A negative test followed by a positive one within one to three weeks is extremely valuable.
(2) Uterine size should be assessed as early as possible. The correlation between gestational age and uterine size is best in the very early stages of pregnancy. Repeated size versus gestational age assessment should be continued throughout pregnancy.
(3) Patients should be instructed to write down the date when they feel the baby move for the first time (usually 16 to 20 weeks).
(4) Fetal heart rate auscultation with a fetoscope should be done at every visit. This landmark is very important as the baby's heart tones are first heard with a fetoscope around 20 weeks in almost all pregnant patients. Heart tones are usually first heard with the "doptone" at approximately 12 menstrual weeks.
(5) Ultrasonic determination of the fetal biparietal diameter should be performed twice. The first time at approximately 21 to 25 weeks by size and the second time at ap-

From the Department of Obstetrics-Gynecology, University of Wisconsin-Madison Medical School and Wisconsin Perinatal Center, Madison General Hospital, Madison, Wisconsin. Publication support provided. Reprint requests to: Wisconsin Perinatal Center, Southcentral Region, 202 South Park St, Madison, Wis 53715. Copyright 1979 by the State Medical Society of Wisconsin.

proximately 31 to 32 weeks (as calculated from the first biparietal). Not only are biparietal diameters most accurate between 21 to 31 weeks but also the two measurements will increase accuracy by making it possible to determine the growth adjusted sonographic age (GASA).[1]

By following this protocol we have been able to date pregnancies in patients with unreliable dates with reasonable accuracy. However, it is of the utmost importance that such patients be identified early, as the most accurate means for dating the pregnancy can only be used early in gestation. A high index of suspicion followed by active investigation will minimize the problem of unreliable gestational age.

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Abstracts

Tendency of fluorouracil to conceal deep foci of invasive basal cell carcinoma

FREDERIC E MOHS, MD; DANIEL L JONES, MD; and ROBERT F BLOOM, MD, University of Wisconsin, Madison, Wis:

Arch Dermatol 114:1021-1022 (July) 1978

Topical fluorouracil treatment of invasive basal cell carcinoma of the face can result in partial or complete healing of the skin overlying deeper extensions of the neoplasm. The misleading appearance of control may persist for months or years as the cancer invades deeply and extensively before its presence again becomes clinically obvious. These conclusions are based on data obtained during the microscopically controlled excision of 103 invasive basal cell carcinomas of the face that had recurred after topical fluorouracil treatment.

Although topical fluorouracil is effective in the treatment of multiple actinic keratoses, its use in the treatment of skin cancer usually is limited to superficial basal cell carcinomas that are common on the trunk and extremities but rare on the face. These neoplasms belong to a distinct entity characterized by their superficial and noninvasive growth even though they may spread radially to a large diameter. However, even superficial basal cell carcinomas can have somewhat deeper downgrowths and unrecognized peripheral outgrowths that are not regularly reached by topical fluorouracil. Therefore, a five-year followup is essential. The same precaution is important when topical fluorouracil is used in the treatment of Bowen's disease and erythroplasia of Queyrat because these entities can evolve into invasive squamous cell carcinoma.

Invasive cancers of the skin can be highly aggressive and destructive and can cause great disfigurement and morbidity. No simple treatment by topical applications has been found that can consistently eradicate these tumors. Each case should be individualized and the best approach available should be used as the primary treatment. Topical fluorouracil should not be included in the methods used to treat invasive basal cell carcinoma. ■

Exertional Heatstroke in Novice Runners

PETER G HANSON, MD; STEPHEN W ZIMMERMAN, MD, University of Wisconsin Center for Health Sciences, Madison, Wis:

JAMA 242: 154-157 (July 13) 1979

Organized road races are a frequent source of heat injury emergencies. Community sponsored runs in Wisconsin frequently attract 500-1000 participants. Novice runners in these races are especially prone to exertional heat injury. They may attempt to complete distances beyond their level of training or run at excessive rates to finish, possibly ignoring premonitory symptoms of heatstroke.

From May to September 1978 we treated four cases of exertional heatstroke in novice runners, all males 24-37 years old weighing 68-88 kg. Three cases involved races of 16, 36 and 42 km at temperatures of 24-26 C and relative humidity of 62-64%. The fourth case occurred in a 10 km run during ideal weather conditions (15 C, 60% relative humidity). In each case the runner attempted to increase his running pace near the end of the race. The onset of heatstroke occurred within 5-10 minutes of the increased effort. Clinical findings included unconsciousness or extreme disorientation, average rectal temperature 41.5 C and hyperdynamic circulatory state (heart rate 120-140, blood pressure 140-100/60-0). Active sweating was present in each case. All were treated in the field with rapid cooling and intravenous fluid therapy and were hospitalized for 48 to 72 hours. The clinical and laboratory findings were consistent with acute exertional heatstroke.

Sponsors of road races should provide adequate pre-race information emphasizing current environmental conditions, fluid replacement, and recognition of injury symptoms. Runners should be cautioned not to attempt an increase in running pace in warm weather. On-call physicians and emergency personnel should be familiar with evaluation and management of possible heat injury victims from local road race events. ■

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†See Warnings, Precautions and Adverse Reactions.

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For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with. Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur AOVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness, weakness; dizziness, insomnia, nausea, vomiting; impotence, suppression of lactation, constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE ANO AOMINISTRATION Oosage must be adjusted to individual patient's needs
Usual Dosage Bentyl 10 mg capsule and syrup *Adults*. 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water.) Bentyl 20 mg : *Adults* 1 tablet three or four times daily Bentyl Injection: *Adults* 2 ml. (20 mg) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Oecatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S A

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Hodgkin's disease update

At the Midwest Cancer Seminar held in Madison in September "Hodgkin's Disease" was the topic of the memorial address presented by Henry S Kaplan, MD in memory of William L Caldwell, MD, the former director of the Radiotherapy Division of the Wisconsin Clinical Cancer Center.

Doctor Kaplan is the Maureen Lyles D'Ambrogio Professor of Radiology and Oncology and Director of the Cancer Biology Research Laboratory of the Department of Radiology at Stanford University Medical School. He was the teacher, friend, and close colleague of Doctor Caldwell. This disease was an appropriate subject for the memorial lecture because Doctor Caldwell truly believed in multidisciplinary activities aimed at optimizing the care of the cancer patient.

Until about 1950 Hodgkin's disease was one of the most puzzling medical problems imaginable. No one knew whether it was an infection or a neoplastic disease. Nothing was known about how it spread. Because it could not be cured, only palliative treatment was usually given.

Through the efforts of many scientists and physicians, it is now known that Hodgkin's disease is a neoplasm, but one of the strangest known. In his lecture Doctor Kaplan very clearly summarized the changes which have taken place in our understanding of the disease and our ability to manage it successfully.

In order to make an accurate diagnosis and determine the stage of the disease, the physician must be sure to rule out false diagnosis due to use of diphenylhydantoin (Dilantin®), infectious mononucleosis, or cat scratch disease. He should record if the patient has lost more than 10% of body weight in the last five to six months, has night sweats, or has a fever. During the physical examination, special attention should be paid to the lymph nodes, liver, and spleen. Chest x-ray films should be obtained. Whole lung tomography can indicate if mediastinal or hilar nodes are involved. Bilateral lymphangiograms of the lower extremities can help determine if there is lymph node involvement below the diaphragm; however, they will not demonstrate celiac or mesenteric nodes. Computerized tomographic (CT) scans also may be helpful. Laboratory tests should include erythrocyte sedimentation rate, serum copper to indicate the level of disease activity, and perhaps serum iron.

A staging laparotomy should be done in selected patients. It is recommended that a splenectomy be done at this time, since about half of the patients have false positive enlarged spleens on physical examination, while others with nonpalpable spleens proved positive on biopsy. One cannot tell if the spleen is involved without a biopsy. All patients with liver disease also had involvement of the spleen. The spleen was the best indicator of liver involvement. All patients with positive bone marrows also had splenic involvement. The surgeon should likewise do a mesenteric lymph node biopsy and iliac crest bone marrow biopsy. To be accurate the bone marrow should not be aspirated but a cutting needle used for the biopsy. Overall there is a change of stage in 31% of the patients as a result of the laparotomy.

Treatment usually consists of radiotherapy and/or chemotherapy. Present day radiotherapy is successful because tumoricidal doses may be given to large fields using megavoltage beam energies. If it is necessary to irradiate the abdomen of a woman who is still of child-bearing age, it is possible to move her ovaries and attach them into a position where menstrual function will not be affected.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

Several different combinations of chemotherapeutic drugs are currently being used to treat Hodgkin's disease. These combinations are highly effective in inducing complete remissions. The agents used produce additive antitumor effects without increasing host toxicities. Nevertheless significant toxicity is necessary before complete remission can be achieved.

The MOPP combination (nitrogen mustard, vincristine [Oncovin®], procarbazine, and prednisone) has permitted patients with advanced state III or IV Hodgkin's disease to achieve complete remission 81% of the time. Sometimes bleomycin is added to these drugs. The ABVD regimen (adriamycin, bleomycin, vinblastine, and DTIC) not only gets new patients into remission but sometimes can be used to induce remission in patients who have failed MOPP therapy. The B-CAVe combination (bleomycin, CCNU, adriamycin, and vinblastine) also can be employed in salvaging patients who have relapsed. Care must be taken with MOPP therapy, for stopping prednisone can trigger reactions following radiotherapy.

Radiotherapy is probably the best form of treatment for stage I, II, and IIIA disease normally. Alternating treatments with radiotherapy and chemotherapy permits better toleration of the treatment by the patient and provides a better prognosis for those with stage IIIB disease. Stage IV disease which has extended to the bone marrow needs chemotherapy and low dose radiotherapy, while disease in the liver or lung requires MOPP plus radiotherapy.

Doctor Kaplan concluded this memorial lecture by stating that about 65% of all patients with Hodgkin's disease now survive at least ten years from the time of diagnosis. Since 95% of all relapses occur by five years and most by ten years, there is a good chance that these patients have been cured and have a normal life expectancy. The most impressive recent gains in treatment have been observed in patients with stage III and IV disease at the time of diagnosis.

This optimistic picture is clouded by the concern of oncologists who have seen the development of a significant number of second malignancies in those patients who were treated with combined radiotherapy and chemotherapy. The risks appear to be doubled in these patients, so physicians must not just arbitrarily add chemotherapy to radiotherapy in every patient with Hodgkin's disease. As yet no second malignancies have been reported in patients who have been treated with ABVD, but only a short time has elapsed since this treatment modality was developed and used in patients.—Dorothy J Buchanan-Davidson, PhD, Science Writer, Wisconsin Clinical Cancer Center

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"Nutrition in Cancer" conference

The University of Wisconsin Clinical Cancer Center is sponsoring a "Nutrition in Cancer" conference, Friday, December 7, in Auditorium G5/119, University of Wisconsin Clinical Science Center, 600 Highland Ave, Madison. See details in the YELLOW PAGES section of this issue. ■

Organizational SMS

X-ray certification bill recommended for passage

The Assembly Health & Social Services Committee has recommended passage of a bill requiring certification of all x-ray machine operators in the state, including physicians. Under AB 824 medical, dental, nursing, and chiropractic examining boards would individually establish certification requirements and all would require passage of a test for certification. Recertification of all x-ray operators would be mandated every five years. Prescribers of x-rays would have to meet continuing medical education requirements as determined by the boards.

The SMS and its Governmental Affairs Commission are working on an alternative to AB 824 in an effort to provide continuing assurance of public safety during radiologic testing. Physicians are strongly urged to contact legislators in opposition to AB 824 and in support for certification standards of radiologic technicians. Without this contact physicians may be required to pass competency tests in addition to their medical license.

The Wisconsin Legislature has been busy acting on several pieces of health-related legislation in recent weeks. Among them:

- Assembly Bill 654, which would allow attorneys to base their contingency fees on awards made for future medical expenses in malpractice actions, was tabled by unanimous consent of the Assembly. Presently attorneys are allowed to base their contingency fees on the first $25,000 of an award. State Rep Barbara Ulichny (D-Milwaukee) moved for tabling due to a wide lack of support for the bill among Representatives. SMS OPPOSES.
- Wisconsin's Clean Indoor Air Bill, Senate Bill 30, after barely surviving a vote for indefinite postponement, was sent to a third Senate Committee for further review. The bill prohibits smoking in most public buildings and conveyances unless specifically designated as a smoking area by placement of a sign. SMS SUPPORTS.
- Senate Bill 181, the "Brain Death Bill," was dealt a blow by the Senate Human Services Committee which voted to indefinitely postpone the measure 4-1. Committee Chairman Sen Carl Thompson (D-Stoughton) must now decide whether to leave the bill in Committee or report it out with the unfavorable recommendation for Senate floor action. SMS SUPPORTS.
- The Senate Education and Revenue Committee has voted 3-2 not to take action on a bill establishing an optometric student loan forgiveness program. SMS opposes SB 149 since it would finance the loan forgiveness program through general purpose revenue funds and not through tuition increases as have been applied to physicians.
- The State Assembly passed AB 326, dealing with statute of limitations for malpractice actions, after the State Medical Society was successful in securing an amendment allowing malpractice actions to be initiated within three years of the incident or one year from the discovery of injury, not to exceed five years (or age ten, whichever is later for minors) from the date the injury occurred. Originally the bill called for expanding the statute of limitations to six years. Present Wisconsin statutes do not have a "discovery" clause. AB 326 has been sent to the Senate Judiciary Committee for action.

Fall flu program begins

The Division of Health reports it has received the 1979-80 influenza vaccine for combating the following flu strains expected to be prevalent this season: A/Brazil/78, A/Texas/77, and B/Hong Kong/72. These vaccines are available to physicians at no charge. For more information contact the 1979-80 Influenza Control Program, Bureau of Prevention, Division of Health, PO Box 309, Madison, Wis 53701.

SMS opposes minor consent bill

The SMS Commission on Governmental Affairs has acted to oppose a bill (SB 188) permitting health care professionals to provide medical service to consenting minors, if the health care professional believes the minor understands the nature and consequences of the service. The Commission said the bill interferred with parental rights and the responsibilities they have accepted to raise a child.

In other action the Commission:

- Supported the concept of the licensure of nurse-midwives to practice in a hospital setting, but outside the hospital only under the supervision of a physician.
- Supported AB 246 requiring the Department of Health & Social Services to provide instruction on the treatment of anaphylactic shock (including administering injections) resulting from insect sting to all current and future emergency medical technicians. The Commission also recommended an amendment to the bill requiring the EMT to be in contact with a physician before administering an injection.

Future of health care probed at October conference

"Physicians and hospital management must get together and come up with a solution to the healthcare cost problem or they will die of 'terminal regulationitis'," warned Walter McClure, a Minnesota economist and a featured speaker at "Health Care in the 80's: Options for Survival" conference the State Medical Society of Wisconsin and Wisconsin Hospital Association held in Delavan October 12.

"The underlying cause of the cost problem and the maldistribution of healthcare resources is the absence of market forces," McClure told the 100 physicians and hospital executives in attendance.

McClure said the answer to this problem lay in creating competition between providers over premiums. He said organized provider groups such as health maintenance organizations (HMOs) and individual practice associations (IPAs) should be encouraged to compete with individual providers in trying to offer patients the highest quality service at lower premium costs.

"The real problem," McClure said, "was that incentives in medical care on patients, physicians, and hospitals are cost-generating instead of cost-effective."

"You are penalized for being cost-effective in the present system," McClure stated. "Doctor, if you don't perform treatments whose worth is not yet proven, and tests whose cost-effectiveness are questionable, you lose revenue."

"If you're a hospital and do early discharge and testing at outside facilities, you go broke," McClure added.

McClure believed that medical market competition can achieve lower costs by forcing more economic operations and changing the incentive for both doctors and patients.

"In any future medical care system, you (physicians and hospitals) will not be allowed to do everything you know how to do. It will take sacrifice on your part and you will have to prioritize what you do. You will not have the same degree of professional freedom ten years from now as you have today."

In regard to hospitals, McClure said the US could easily retire at least 20% of its hospital capacity, including excess beds, labor, equipment, and capital

Rise in 1979 membership

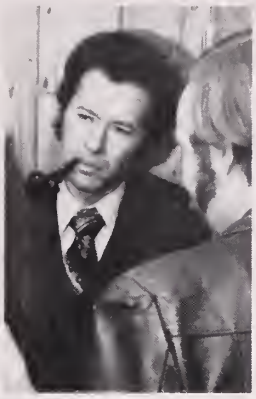
The SMS Membership Department reported a mid-October membership increase of 59 over last year's figure at this time. Records currently show 4638 members as compared to 4579 members by mid-October 1978.

New dues payment plan

SMS members will be able to pay their 1980 dues by using either Master Charge or VISA credit cards because of a new plan arranged through the First Wisconsin National Bank. Members also are reminded that other methods for dues payment—including writing a check for the full amount and the installment payment plan—are still in effect. Under the installment payment plan, members can pay one-half of their dues by January 1 and the other half by May 1.

A new post office box has been established for payment of 1980 dues. SMS members are asked to send their dues payment to: State Medical Society of Wisconsin, PO Box 8425, Madison, Wis 53708.

Physicians should send all other correspondence to SMS at PO Box 1109, Madison, Wis 53701.



PARTICIPANTS: (left to right) Darold A Treffert, MD, Fond du Lac, president of the State Medical Society; US Representative John Anderson, Rockford, Illinois; Walter McClure, PhD, Minneapolis, Minnesota, vice-president of InterStudy; Paul Kempe, administrator of Columbia Hospital, Milwaukee; and Blake Waterhouse, MD, medical director of the Jackson Clinic, Madison (Staff photos by Neal Neuberger).

"In many cases, the most cost-effective thing a hospital could do is close," he said.

"Some of you here today may think that all this talk about competition is unprofessional," McClure said, "Well, if you think that's unprofessional, then perhaps you think working for Uncle Sam is professional—because that's who you will be working for."

Following McClure's talk, participants broke up into discussion groups to explore options for cooperative efforts between physicians and hospitals in the areas of cost containment, government regulation, physician distribution, and alternative delivery systems.

For the afternoon session the podium was turned over to Ralph Andreano, professor of economics at UW-Madison and former administrator of the State Division of Health to probe Wisconsin's experience in the healthcare system.

Addressing a multiplicity of topics from health planning and rate review to certificate-of-need and PSROs, Andreano blasted the Wisconsin Rate Review Committee by saying that hospital rate increases were more than one-third higher on an annual basis over the past five years than those actually approved by the committee.

Figures from a study on hospital rate increases Andreano recently conducted showed that hospital rates increased 15.73% during each of the last five years. In only one-fifth of the total 584 observations comprising the study, was the per diem approved by the Rate Review Committeee the actual per diem.

He said according to Rate Review Committee figures, 11.49% in rate increases was requested from the committee and rates approved by the committee were 10.35%.

Some of the increase was due to hospitals coming back more than once a year for a rate increase while an even larger portion of the increases was due to what Andreano termed the "tube-of-toothpaste" effect. Since Blue Cross, one of the principal participants in rate review process will only reimburse hospitals what the committee approves, hospitals strained financially recover their actual daily rates from payors other than Blue Cross, Andreano said.

The UW economics professor also chided the rate review system for "leaving out one of the key actors—the physician."

"Physicians' actions probably give them 75% decision-making control over total expenditures," he stated.

Andreano did concede, however, that rate review probably has had some success in keeping hospital expenditures down.

In regard to certificate-of-need, Andreano said it alone as a regulatory tool had many problems, but the "basic problem lies in how do we effectively evaluate its effectiveness?"

He said something has to be done about the dollars being spent for personal healthcare in Wisconsin and that nursing home and drug expenditures are "really out of line."

While Andreano said regulation was not a real substitute for market forces in the healthcare system, he maintained government intervention will be necessary to hold costs down in the future.

Delivering the luncheon address at the conference was US Representative John Anderson, a candidate for the Republican presidential nomination.

Anderson said that "improvements in the physical health of the American people can be made within the existing national health system without resort to comprehensive national health insurance."

"The greatest improvements in health care," Anderson said, "have been made through intensive research and in particular through improved understanding and treatment of prenatal, neonatal, and early childhood illness. Rather than turning our backs on what has worked, we should redouble our efforts to improve medical performance in these traditional areas."

"Health Care in the 80's: Options for Survival" was sponsored jointly by the State Medical Society of Wisconsin and the Wisconsin Hospital Association. It brought together physicians and hospital chief executive officers in Delavan to look at the future directions of the healthcare system.

Chiropractic bill defeated in Senate

On the first day of the fall legislative session, October 2, the State Senate voted down SB 30 requiring all health insurers to include chiropractic coverage in their health insurance contracts. By a vote of 17-16, the Senate "indefinitely postponed" SB 30, killing the bill for this legislative session. The Senate later defeated a motion to reconsider postponement 22-11.

State Senator Carl Thompson (D-Stoughton), speaking in support of the bill, warned the senators that if they defeated the bill this session, "it would come back to haunt them." Thompson, who chairs the Senate Health and Human Services Committee, urged the chiropractic and medical groups to work with his committee in developing a compromise.

State Senator Thomas Harnisch (D-Neillsville) told the legislators that passing SB 30 would "only open doors for others, including psychologists, social workers, and dentists to seek inclusion in healthcare programs."

In other action October 2, the Senate passed Assembly Bill 243 prohibiting healthcare providers and others from imposing a fee for completing health or disability claim forms when these forms are necessary for the patient to receive his/her benefits. The State Medical Society, which opposed the bill in its original form, was successful in securing an amendment permitting charging for duplication or reproduction costs in connection with insurance claims. Charging for completing initial uniform claim forms has long been considered unethical by SMS.

On hand to lend support to the Medical Society lobby October 2 were more than 70 members of the SMS Auxiliary who attended the morning legislative session, and later they hosted an informal luncheon for Wisconsin legislators.

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

Late legislative notes

- The Legislature adjourned on November 2 and will not reconvene until Jan 29, 1980, unless by call of a special session.
- Assembly Bill 203, mandating coverage of chiropractic services in all health insurance contracts, received a favorable recommendation from the Assembly Financial Institutions Committee. Before recommending the bill the Committee adopted a substitute amendment to the bill which would allow persons to "opt-out" of the mandated coverage.
- The Assembly deferred action on a bill (AB 67) which would mandate health insurers to cover services of clinical psychologists, if coverage is extended for similar services by physicians. SMS is opposed to this bill and the concept of mandated insurance coverage for individual disciplines, since it has great potential for driving up health insurance costs.

Title 19 "SuperRule" to be published

The State Department of Health and Social Services has announced that the Title 19 "SuperRule"—the medical assistance recodification rule which has been three years in the making—will be published December 1. Providers will have until January 31 to review the rule which will become the official policy of the Wisconsin Medical Assistance Plan (WMAP) when promulgated February 1, 1980. Provider agreements will be distributed sometime in December with a March 1 deadline for signing.

The Title 19 Provider Agreement, which is required by state and federal law, replaces the 1978 four-page "Contract." Its two basic statements are that the physician agrees to abide by the laws and the rules of the Wisconsin Medical Assistance Program and that the physician accepts T-19 reimbursement as payment in full for his/her services.

The December issue of WMJ will carry a summary of the "SuperRule" contents to provide SMS mem-

MEDICAL EXAMINING BOARD

William Baker, MD, chairman of the State Medical Examining Board, has appointed a committee to study the older-age aspects of impaired physicians. Appointed by Doctor Baker were: Darold Treffert, MD, Fond du Lac, chairman; John Rupel, MD, Marshfield; and Ted Besser, Administrator at New London Community Hospital.

In a joint meeting with the State Pharmacy Examining Board October 18 the MEB went on record as supporting the idea that any facility, including a physician's office or clinic, which dispenses drugs, has to have a license and comply with the same regulations of a pharmacy dispensory such as record keeping, prescription labeling, etc. The PEB currently is introducing legislation to amend Chapter 450 of the Pharmacy Laws to include this language. The MEB has requested the PEB to give it guidelines on how physicians can comply with the proposed legislation. The PEB says it expects fewer than 10% of the state's 6,000 physicians to maintain dispensories.

bers with as much information as possible in a compact format.

Copies of the "SuperRule" will be available to all physicians who wish to review it prior to implementation. Requests should be directed to: Ms Becky Lawver, Bureau of Health Care Financing, Room 325, 1 West Wilson St, Madison, Wis 53702 (ask for: Wisconsin Administrative Code [HSS 2—"SuperRule"]).

MDs participating in Health Plan drafting process

Jack Peters, MD, Fond du Lac, chairman of the Health Policy Council's Plan Development Committee reports that work is well underway in preparing the 1980 State Health Plan. The State Medical Society was asked to participate in this process by providing recommendations for physician members of the State Health Plan Development Subcommittees which are preparing the diagnosis and treatment sections of the 1980 State Health Plan.

The following physicians have been selected by HPC for service: GENERAL MEDICAL SERVICES: John Renner, MD, Madison; Michael Garrity, MD, Prairie du Chien; PATHOLOGY AND RADIOLOGY SERVICES SECTIONS: George Kindschi, MD, Monroe; Stanley Inhorn, MD, Madison; Homer Russ, MD, Marshfield; Albert Alter, MD, Madison; OB AND GENERAL SURGERY SERVICES SECTIONS: Derward Lepley, MD, Milwaukee; Richard Sholl, MD, Janesville; Walter Rattan, MD, Kenosha; Robert Holly, MD, Milwaukee; James Esswein, MD, Chetek; DENTAL AND VISION CARE SERVICES SECTIONS: Dennis Ryan, MD, LaCrosse; John Ridley, MD, Mequon; PREVENTION AND DETECTION: Curtis Bush, MD, Beaver Dam; J D Kabler, MD, Madison.

The preliminary draft of the 1980 State Health Plan is due to be completed by January 1980 with public hearings slated during the months of February and March 1980.

HMO/IPA paper available

A paper discussing the organization and operation of Health Maintenance Organizations and Individual Practice Associations in Wisconsin is available upon request from SMS Offices in Madison. The paper highlights the advantages and disadvantages, various types of HMOs/IPAs and provides references for further information.

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Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of October 15, 1979

NEW MEMBERS

County Medical Society

DANE

Behrens, Scott A, 4115 Meyer Ave, Madison 53711 (1952, Resident, Anesthesiology)
Fulks, Michael W, 600 N Highland Ave, Madison 53792 (1947, Resident, Internal Medicine)
Garnett, James G, 130 N Kenosha Dr, Madison 53705 (1949, Regular, Anesthesiology)
Oberley, Terry D, 420 N Charter St, Madison 53706 (1946, Regular, Pathology)
Reinholtz, Paul E, 5722 Raymond Rd, Madison 53711 (1950, Regular, Family Physician)
Teetzen, Merle L, 230 Randolph Drive, #112, Madison 53717 (1947, Resident, Neurology)

OZAUKEE

Shewczyk, Thomas J, W62 N563 Washington Ave, Cedarburg 53012 (1947, Regular, Family Physician, Certified)

ROCK

Bodley, Don H, 510 North Terrace, Janesville 53545 (1943, Regular, Orthopedic Surgery, Certified)
Madan, Suresh K, 3927 Springhill Dr, Janesville 53545 (1947, Regular, Internal Medicine)

WAUKESHA

Hovey, John C, W180 N7950 Townhall Rd, Menomonee Falls 53051 (1945, Regular, Ophthalmology/Aerospace Medicine, Certified-OPH)
Lofland, Leo J, 447 Kimberly Dr, Waukesha 53186 (1939, Resident, Family Physician)
McWhirter, Robert E, W180 N7950 Townhall Rd, Menomonee Falls 53051 (Orthopedic Surgery, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Grieve, Bonnie-Jo M, Madison, to 10421 Gotham Rd, Richmond, VA 23235
Hanson, Jerome T, Madison, to 6110 N Bay Ridge Ave, Whitefish Bay 53217

EAU CLAIRE-DUNN-PEPIN

Cameron, William G, Eau Claire, to 250 Palmer Blvd, North Fort Myers, FL 33903

JEFFERSON

Netzow, Earl J, Cedar Grove, to Seabrook Island, High Hammock Villa A-Z, Johns Island, SC 29455

MANITOWOC

Farkas, Mary E L, Alaska, to USAF Hospital ATC, Mather AFB, CA 95655
Lockey, James E, Manitowoc, to 1746-3 Bising St, Cincinnati, OH 45239
Radl, Cyril J, Manitowoc, to Apt A-108, 7350 Via Paseo Del Sur, Scottsdale, AZ 85258

MARATHON

Prehn, Fred C, Wausau, to 9 High Point Circle N, Naples, FL 33940

MILWAUKEE

Kustermann, John A, New Cumberland, PA, to 350 Ala Moana Blvd, PO Box 50266, Honolulu, HI 96850
Mayr, James F, Kittery, ME, to 3814 South 56th St, Milwaukee 53220
Moore, George E, Milwaukee, to Rte #1, Ashland, IL 62612
Ryan, Paul W, Delafield, to 1509 Coachman Dr, Mountain Home, AR 72653
Waitzman, Jeffrey S, Milwaukee, to 1585 Ellinwood St, Des Plaines, IL 60016

PIERCE-ST CROIX

May, John A, Baldwin, to 6863 NW Fourth St, Des Moines, IA 50313

RACINE

Gerol, A Yale, Racine, to 1355 North Beaver St, Flagstaff, AZ 86001

ROCK

Farnsworth, R W, Janesville, to 301 North Ocean Blvd, Pompano Beach, FL 33062

SHAWANO

Pearlman, Jeffrey J, Keshena, to 2337 Monticarlo Circle, Plano, TX 75075

WINNEBAGO

Stelter, Gerald P, Neenah, to 3601 Barbados Drive, Augusta, GA 30909

WOOD

Gibson, Mark S, Marshfield, to 2409 Northgate Terr, Silver Spring, MD 20906
McConnell, Rex A, Marshfield, to 123 Rock St, Marquette, MI 49855
Molina, J Ernesto, Marshfield, to Mayo Bldg, Box 472, Minneapolis, MN 55455
Wood, Michael, Marshfield, to 21A South Brown St, Rhinelander 54501

DEATHS

Lenz, Ralph B, Brown County, Sept 15, 1979
Wasserburger, R H, Dane County, Sept 16, 1979
Sannes, W Andreas, Crawford County, Sept 17, 1979
Troup, Ralph L, Brown County, Sept 29, 1979 ■

Average MD works 50 hours per week, study shows

The average office-based American physician now works 50.3 hours and provides 130.6 patient visits each week, according to the latest edition of the American Medical Association's Profile of Medical Practice 1979. The average office-based physician worked 47 weeks in the year, with five weeks off for vacation and for attending continuing medical education seminars. Surgeons in 1978 worked the longest hours per week, 53.2. Physicians in larger cities worked shorter hours than those in small towns or rural areas. Copies of Profiles of Medical Practice in 1979 may be purchased for $6.00 from Center for Health Services Research and Development at the AMA in Chicago.

Obituaries

◈County, State, AMA Members

◈ **Bernard J Werra, MD,** 70, Waukesha, died Aug 16, 1979 in Waukesha. Born Dec 8, 1908 in Manitowoc, Doctor Werra graduated from Marquette University School of Medicine in 1941. A member of the medical staff at Waukesha Memorial Hospital, Doctor Werra joined the staff in 1947 and retired in 1972. He started what today is known as the Cardiovascular Department at the hospital and also is credited with starting the hospital's inhalation therapy department in 1963. A World War II veteran, Doctor Werra participated in the invasion of Iwo Jima in the South Pacific. Surviving are his widow, Mary; two sons, Anthony, Milwaukee, and Bernard, Waukesha; and two daughters, Mrs Robert (Annette) Sprader, Waukesha, and Mrs Bruce (Jean) Zwijacz of Milwaukee.

◈ **Sarkis H Kash, MD,** 84, retired Cudahy health commissioner and school physician, died Aug 18, 1979 in Cudahy. Born Sept 6, 1894 in Armenia, Doctor Kash graduated from the University of Michigan Medical School in 1917. Doctor Kash served as city health commissioner for 27 years. Surviving is his widow, Dorothy of Cudahy.

◈ **Richard H Wasserburger, MD,** 56, Madison, Director of the Electrocardiography Interpretation Program of University of Wisconsin Hospital and Clinics, died Sept 16, 1979 in Madison. Born Oct 18, 1922 in Minocqua, Doctor Wasserburger graduated from the University of Wisconsin Medical School, Madison, in 1946 and served in the United States Air Force as a depot surgeon in Germany from 1947 - 1949. Doctor Wasserburger was chief of cardiology from 1953-1971, and assistant chief of medicine at the Veterans Administration Hospital, Madison, while a member of the medical faculty attaining full professorship in 1964. He was a member of the Central Society for Clinical Research, American Board of Internal Medicine, American Board of Pulmonary Disease, and was active in the programs of the Wisconsin Heart Association. In 1978 he received the award for Distinction from the American Heart Association. Active in the Independent Study Program and Continuing Medical Education programs of the University of Wisconsin Medical School, Doctor Wasserburger was cited for teaching excellence by medical students, residents, and paramedics and was considered one of the most honored teachers in the history of the Medical School. He was past president of the Medical Alumni Association and in 1975 he received the Medical Alumni Citation, the highest honor of the Association.

In 1969 he was appointed to serve on the Commission on Scientific Medicine (now the Commission on Continuing Medical Education) of the State Medical Society of Wisconsin. He served two years of his five-year term and resigned because of ill health.

Surviving are his widow, Helen, three daughters, Mrs Thomas (Marguerite) McDowell, Lori, and Heidi; and three sons, Richard, Jon, and Kim Neal.

◈ **William A Sannes, MD,** 77, Soldiers Grove physician since 1933, died Sept 17, 1979 in Soldiers Grove. Born Jan 14, 1902 in Oslo, Norway, Doctor Sannes graduated from the University of Cincinnati School of Medicine in 1930. He retired from medical practice in 1978. Surviving are his widow, Eda; a son, Donald, Soldiers Grove; four daughters, Mrs Marvin (Mary) George, Edgerton; Margaret and Mrs Gary (Karn) Dull, Madison, and Mrs Jerry (Noreen) Waller of Bartlett, Illinois.

Don H Martin, MD, 46, Milwaukee, died Sept 19, 1979 in Milwaukee. Born Feb 1, 1933 in Norton, Kansas, Doctor Martin graduated from Marquette University School of Medicine in 1959. He served in the United States Navy from 1960 - 1962. ■

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County Societies

DANE: At its Annual Meeting, October 9, the Dane County Medical Society elected the following officers for 1979-1980: David W Semian, MD,* Madison, president-elect; Conrad L Andringa, MD,* Madison, vice-president; and R Marshall Colburn, MD,* Madison, secretary-treasurer. DCMS Board of Trustees members-at-large elected for two-year terms expiring in 1981 are: John J Ouellette, MD* and Ralph B Froelich, MD,* both of Madison.

The following were elected to the SMS House of Delegates for two-year terms expiring December 31, 1981: MDs Sandra L Osborn,* John H Morledge,* Charles E Nahn,* James N Moore,* Frederick C Kriss,* Hubert V Moss,* and Dolores A Buchler,* all of Madison, delegates; and MDs John D Wegenke,* John M Shannahan,* David S Grab,* Richard D Lindgren,* Robert B Shapiro,* Robert W Graebner,* and David W Semian,* all of Madison, alternate delegates.

Hubert V Moss, MD,* Madison, was installed as president, succeeding J D Kabler, MD,* Madison. In his acceptance address Doctor Moss said it "is both an honor and a challenge to continue to uphold our profession against the numerous forces which would encourage devisiveness. We all increasingly need to be more aware of cost:benefit ratios. We must be willing to separate out that which is essential from that which is elective. We must work together toward providing quality medical care in an efficient and caring manner. I feel that a unified medical society can greatly help us accomplish this goal."

Toward this end and in way of review Doctor Moss mentioned some of the key activities the DCMS will be undertaking during the coming year: (1) MEMBERSHIP CAMPAIGN—Under the direction of Stephen A Imbeau, MD,* Middleton, an ambitious campaign to recruit all physicians practicing in Dane County to become members of the Society will be undertaken. An effort will be made to personally contact each nonmember and inform him/her of the Society's activities in the legislative, scientific, insurance advisory, social, and all other aspects of Society affairs. (2) COMMITTEE APPOINTMENTS—In an effort to make participation in DCMS more accessible to all members, each member will be sent a list of all standing and ad hoc committees and a brief review of their purpose and activities. Each member will be given an opportunity to indicate his/her interest and willingness to serve on these committees. (3) PHYSICIANS ALLIANCE—A continuation and enhancement of the SMS Physicians Alliance efforts in the socioeconomic, legislative activities, noting that recently legislators have been seeking out the PA for medicine's views, insights, and support on a whole variety of public policy questions. (4) HEALTH PLANNING—Support of the Wisconsin Physicians Planning Network (WPPN) which was formed in response to the federally mandated health planning groups. The local Health Systems Agency (HSA) helps administer the local certificate-of-need program and is responsible for making an Annual Implementation Plan and a five-year Health Systems Plan. Through a locally organized Physicians Task Force, DCMS representatives are continually advising this largely nonmedical agency with indepth analyses which help produce future health planning programs, and thus contribute to the improved delivery of quality healthcare services instead of burdensome policies and regulations.

Doctor Moss concluded, "I am sorry to report that many third-party payors and health planners often equate low cost of healthcare with quality healthcare. It is my sincere hope that during the coming year we can effectively guide these forces toward a balanced program supported by informed, concerned medical society physicians."

ASHLAND-BAYFIELD-IRON: The Tri-County Medical Society of Ashland, Bayfield and Iron Counties has established a public information committee. The purpose of the committee is to give information to the citizens of these counties information regarding health issues. The medical society also intends to inform citizens about health hazards and health maintenance procedures so they will take a more active role in their own healthcare and improve the general health of their communities.

John C Oujiri, MD* of Family Practice Consultants, Ashland, has been named chairman of the public information committee and also as media liaison person for the Tri-County Medical Society. Doctor Oujiri and his two associates, MDs David M Saarinen* and Paul VanPernis,* are in Iron River on Thursdays at the Town Hall.

MILWAUKEE: A hard-hitting seven-page paper reviewing medical services, identifying problems and offering "constructive criticism" has been issued by the Board of Directors of the Medical Society of Milwaukee County. It deals with physicians and auxiliary personnel, hospitals, planning agencies, other governmental units, and the public.

The Society offered 18 general and five specific recommendations, concluding that: "The physician

*Physician members of the State Medical Society of Wisconsin.

Specialty Societies

WISCONSIN PSYCHOANALYTIC STUDY GROUP. Officers of the Wisconsin Psychoanalytic Study Group for the period May 1979-May 1980 are: Joseph G Kepecs, MD, president; George J Martin, MD, president-elect and program chairman; Samuel B Black, MD,* treasurer; and William H Lyons, MD,* secretary.

The Wisconsin Psychoanalytic Study Group, initially the Milwaukee Study Group which was organized in the late 1940s after several Milwaukee psychiatrists started analytic training in Chicago, in 1978 was accepted as an official group of the American Psychoanalytic Association and as a Provisional Society. The officers in 1978 were Saul K Pollack, MD,* president; Joseph G Kepecs, MD, president-elect; and Samuel B Black, MD,* secretary-treasurer.

Until 1978 the group was an informal and spontaneous meeting of colleagues who gathered to exchange ideas, present clinical material, and benefit from the ensuing discussion. Meetings were held monthly except in summer.

The study group plans to continue the tradition of having members give most of the papers; however, it has expressed interest in hearing from distinguished speakers who come to Wisconsin or Chicago. The group meets alternately in Milwaukee and Madison, and includes two members from Illinois. Psychiatrists and others interested in the scientific programs are invited to call any of the officers.

Members of the Wisconsin Psychoanalytic Study Group are: MDs Samuel B Black,* Jack Coheen,* George J Martin, Saul K Pollack,* H David Sackin, and Harvey D Strassman, Milwaukee; Raymond A Headlee,* Elm Grove; Joseph G Kepecs, William H Lyons,* and Mark Trewartha, Madison; Eugene Kinder,* Richland Center; and Lucy and Ralph Zabarenko, Rockford, Illinois. ■

*Physician members of the State Medical Society of Wisconsin

COUNTY SOCIETIES . . .

should be the medical advocate for the patient . . . a buffer against any outside force attempting to modify or substitute a less promising form of treatment . . . for the physician to be forced to compromise a good mental stance about a patient is both primitive toward that patient and a perversion of the physician's duty to serve the best interests of every patient." A complete copy is available from Derward Lepley, MD,* president of MSMC, 411 East Mason St, Milwaukee, Wis 53202.■

MEDICARE TOLL-FREE NUMBER FOR PHYSICIANS

WPS-Medicare now has a special toll-free phone service for the exclusive use of physician providers. This number is:

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As a service to its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference!

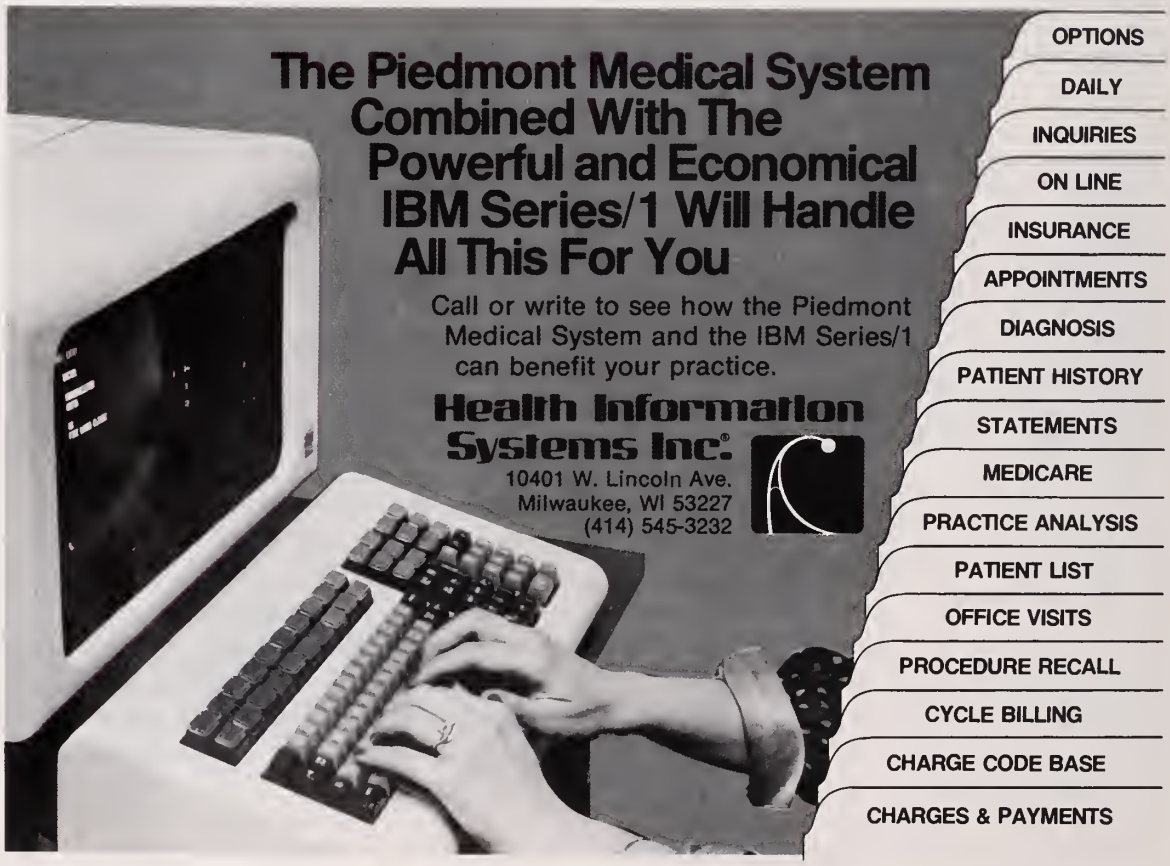
News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Monroe Clinic recently celebrated its 30th anniversary of participation in the University of Wisconsin—Madison Medical School Preceptorship Program. Green County Medical Society was the host for the celebration and UW Dean Arnold Brown, MD was the main speaker. The Monroe Clinic became part of the program in 1949 with Leslie Kindschi, MD* appointed as preceptor. He held this position until 1966 when he stepped down and the role was transferred to Eugene Eckstam, MD.* In the 30 years the clinic has participated in the program, more than 400 medical students have come to the clinic for a two-month period.

Rogers Memorial Hospital, Oconomowoc, has been designated a Hospice Demonstration Project for a two-year period by the US Department of Health, Education, and Welfare. Owen Otto, MD,* president of the hospital board, welcomed the designation as a "breakthrough in our ability to provide hospice services that are so seriously needed by dying patients in our area—southeast Wisconsin. This designation has the effect of suspending many of the restrictions now placed on whom we can serve and how much service we can provide that have been part of the regulations governing Title 19—Medicare—and Title 18—Medicaid. As a designated Hospice Demonstration Project, we will provide HEW with considerable data and experience on the value of hospice care." Rogers' hospice program was inaugurated in January 1978, the first of its kind in Wisconsin. Thomas Holbrook, MD,* psychiatrist, is medical director of the hospice.

Deaconess Hospital, Milwaukee, has announced the election of Randle E Pollard, MD,* Milwaukee, as president of the medical staff. Doctor Pollard, who had been serving as vice-president, also is chief of the section of urology at Deaconess and a clinical associate professor in urology at the Medical College of Wisconsin.



Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Ernest M Drury, MD,* New Richmond physician for 41 years retired from medical practice Sept 7, 1979. A 1937 graduate from the University of Wisconsin Medical School, Doctor Drury served his internship at University Hospitals, Madison. He started practice in New Richmond in 1939 and was interrupted in 1942 by four years in the United States Army Air Corps. He was a member of the medical staff of Holy Family Hospital and in 1970 served as its chief-of-staff.

Marvin E Wagner, MD,* Milwaukee is president-elect of the St Michael Hospital Medical Staff Executive Committee and Daniel J Price, MD,* Milwaukee, is vice-president-elect.

Robert E Condon, MD,* and **John P Kampine, MD, PhD*** recently were appointed as chairman of the department of surgery and the department of anesthesiology respectively, at the Medical College of Wisconsin. Doctor Condon specializes in diseases of the stomach and colon and is director of the Vince Lombardi Colon Clinic at MCW. He will continue as chief of surgical service at Wood VA Medical Center. Doctor Kampine will serve as director of the department of anesthesiology, operating and recovery room services at Milwaukee County Medical Complex. He also will continue to serve as director of anesthesia research at Allen-Bradley Medical Science Laboratory and Wood VA Medical Center.

John J Czajka, MD,* Milwaukee, founder of the Guadalupe Children's Medical Clinic, recently was awarded the Latin Chamber of Commerce's "Person of the Year Award." Doctor Czajka, a pediatrician, opened the Guadalupe clinic in 1969 to provide free medical services to Latins. He is in private practice in Hales Corners and also was the recipient of the 1979 International Service to Mankind Award by the Sertoma International Club.

Youssef Gabriel, MD, Rothschild, recently became associated with the Wausau Clinic in the Department of Neurosurgery. A graduate from Alexandria University School of Medicine, Alexandria, Egypt, he served a rotating internship at Alexandria University Hospital and at Belbase and Coptic hospitals in Egypt. He also served additional residencies at Monmouth Medical Centre, Long Branch, New Jersey and at the Hospital for Sick Children, Toronto, Canada. Doctor Gabriel was an assistant professor of neurosurgery at the University of Saskatchewan, Saskatoon, Canada, prior to joining the Wausau Clinic.

Herbert F Laufenburg, MD,* Cedarburg, recently was appointed director of the Family Practice Residency Program at St Luke's Hospital, Milwaukee. He also is program coordinator of the Emergency Medical Lectures Series at the hospital; medical director of St Luke's Poison Program; a member of St Luke's Mass Casualty Committee, and a faculty member at the Medical College of Wisconsin.

Roy J Thurn, MD, St Paul, Minn, recently became associated with the Hammond Medical Clinic, Hammond. Doctor Thurn formerly had been an assistant clinical professor and associate director of the Family Practice Residency Program at the University of Minnesota. Previous to that, he had practiced medicine in Gowanda, New York, and Duluth, Minn.

Josef Vosmek, MD, Wausau, recently became associated with the Edgar Medical Center. Doctor Vosmek graduated from the University of Wisconsin Medical School, Madison, and served his internship at St Luke's Hospital in Duluth, Minn. He previously had practiced medicine in Kiel. He is a member of the Department of Family Practice at Wausau Hospital.

James T Houlihan, MD,* second from left, Director of Medical Education at the Howard Young Medical Center, welcomes speakers for the 7th Annual Day of Country Medicine recently held in Minocqua. From left, Donald H Schmidt, MD, Mount Sinai Medical Center, Milwaukee; Victor Bernhard, MD,* Professor of Surgery at the Medical College of Wisconsin, Milwaukee; and John W Joyce, MD, Department of Cardiovascular Disease at the Mayo Clinic, Rochester, Minn. (Photo by *The Lakeland Times)*

Richard B Helgerson, MD, Madison, has been named director of the University of Wisconsin Hospital and Clinics Burn Center and assistant professor of surgery at the UW Medical School. A 1971 graduate from Yale University School of Medicine, he served his residency in surgery at the University of Minnesota Medical Center and also completed a fellowship in surgical infectious disease there. Doctor Helgerson succeeds Robert Demling, MD* as director of the Burn Center.

Ricardo Rustia, MD, Kenosha, recently became associated with Nazario R Cruz, MD,* in the practice of general medicine. A graduate of Santo Tomas University Medical School, Manila, The Philippines, he served his internship in Chicago. He recently was discharged after a three-year tour of duty in the United States Air Force.

Ira Kastenberg, MD, recently joined the Northern Oconto County Rural Health Initiative Project. A graduate of the State University of New York, Upstate Medical Center, he served his family practice residency at Deaconess Hospital, Milwaukee. He previously has practiced in Redlodge, Mont, and Hilo, Hawaii. His practice will include office and hospital service in Oconto Falls and physician ambulatory health services at Nicolet Clinic, Lakewood.

Frank M Kraler, MD, Manitowoc, has joined the medical staff of Holy Family Hospital as associate pathologist. He was an associate pathologist at Madison General Hospital and was on the faculty of the University of Wisconsin Medical School. Doctor Kraler's medical education was received in Austria and Switzerland and his internship was served at Danbury Hospital, Danbury, Conn. His residency training was taken at Riverside and Mary Immaculate Hospitals, Newport News, Va.

Charles E Fenlon, MD,* Appleton, has been named general chairman of the 1979 United Way Campaign. Doctor Fenlon is president of the Appleton Family Practice Associates and as of Jan 1, 1980, he will leave his post to assume new duties as director of the new Fox Valley Family Residency Program in Appleton. He will be granted an associate professorship with the University of Wisconsin System.

John Conway, MD,* Appleton, ophthalmologist and otolaryngologist in the Neenah-Menasha area for 30 years, has retired from practice. Associated with the Riverside Clinic and Nicolet Clinic, he served as president of the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology, was chairman of the Ophthalmology Section of the State Medical Society of Wisconsin, and also served as president of the Winnebago County Medical Society. ■

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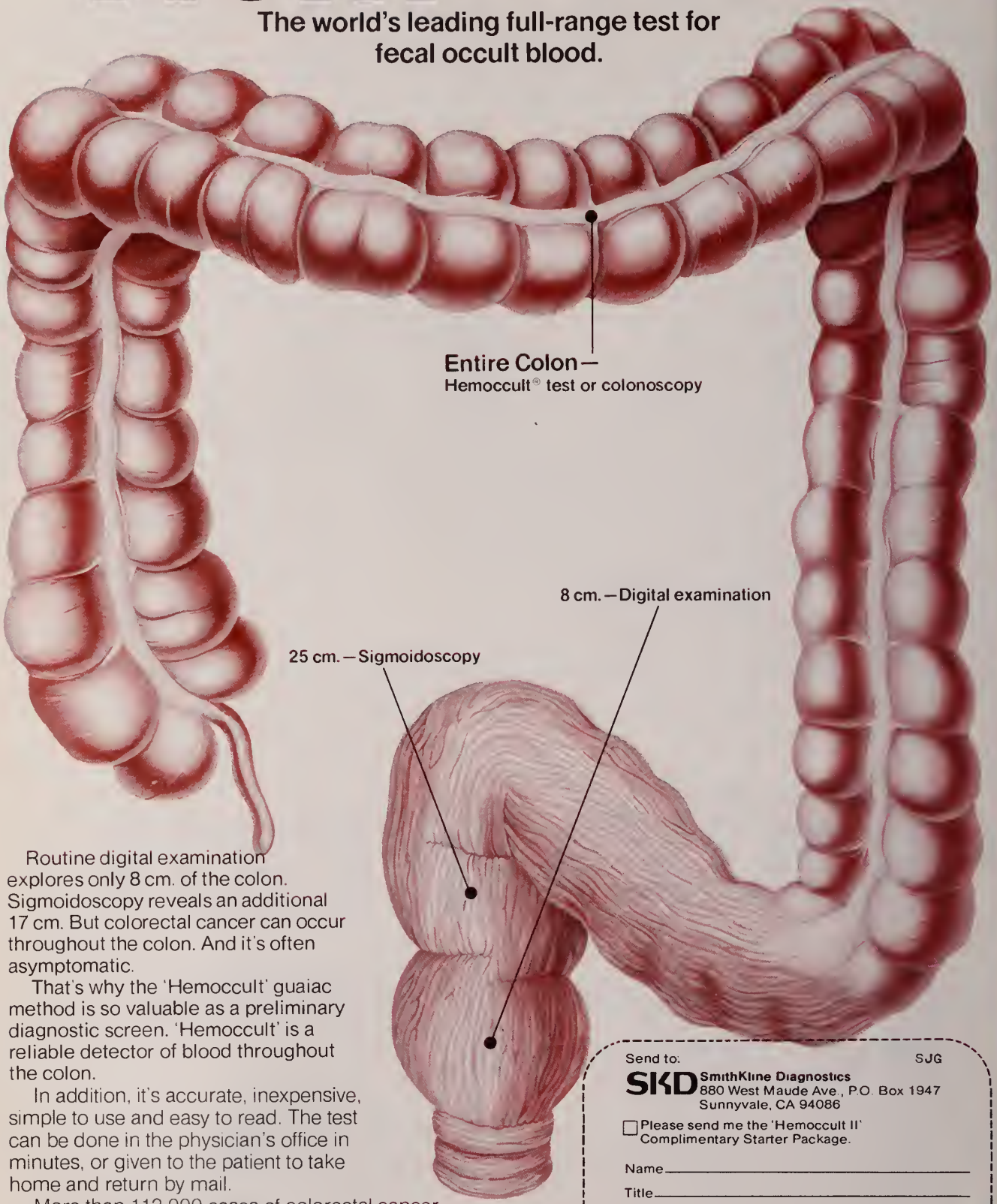

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WPS

report

for Wisconsin Physicians

Volume VIII, Number 6

November, 1979

THE WPS MEDICAL ADVISORY SYSTEM

The health care delivery system has become increasingly complex, with new technologies, new surgeries, and new medical care facilities. These advances in health care are necessary and vital to the continued progress being made in the well-being of the American people.

The cost of these advances has become a source of national concern. Purchasers of health and medical care insurance want their premium dollar used to finance the most cost-effective, medically-appropriate level of health care possible. The great expansion of accessible medical services and the cost of these services necessitate professional medical advice for many health insurance decisions.

The WPS Medical Advisory System provides such advice. The goal of the WPS Medical Advisory System is to assure that the premium dollars of WPS subscribers and beneficiaries are utilized appropriately in the reimbursement of physicians, hospitals, and other providers of care.

Three WPS Medical Advisor physicians in current practice meet weekly with WPS representatives, and thirty-three physicians provide specialized consulting services. The total Medical Advisory Network encompasses a broad spectrum of physician specialties and wide experience in current medical practice.

Primary among the responsibilities of the WPS Medical Advisors is the provision of advice to assist WPS in making reimbursement decisions on claims involving non-routine medical procedures or charges which require additional review.

Examples of claims which may be referred to the Medical Advisors include:

- New and unusual services such as breast reductions, CAT scans, obesity operations or cerebral revascularization surgeries.
- Surgical procedures with high dollar charges.
- Certain expensive durable medical equipment such as air conditioners, motorized wheelchairs, arthritis chairs, braces, or special shoes.
- Extended hospital or nursing home stays.

In claims such as these, the Medical Advisors provide informed opinions only, which may be accepted or rejected by WPS. WPS staff may also obtain several advisory opinions before making a final decision.

Every effort is made to review a Medical Advisory decision when this is requested by a patient or provider. Often, the opinion of a second or third consultant is sought when a review is requested. Decision appeals are presented at the regular weekly Medical Advisor meetings with WPS staff. In the case of appeals under Medicare Part B, which WPS administers in Wisconsin, there is a formalized appeal mechanism designed by HEW. Because appeals are encouraged and respected, and because Medical Advisor decisions are thoughtfully rendered, the decisions are usually accepted by Wisconsin providers.

As experience is gained in a medical area, guidelines and procedures are established and decisions can be made by WPS claims staff without further outside technical advice.

The vast majority of claims received by WPS reflect appropriateness, medical necessity, and sound judgement. For that small percentage of claims which require additional review, the WPS Medical Advisors provide necessary counsel to assure that the premium payer's dollar is used in the most appropriate, cost-effective fashion.

11440-006 7910

COMPLETE SUBMISSION OF CLAIM DATA

Both you and WPS want to have your patient's claims processed as rapidly as possible. Claims which are held up for various reasons generate time-consuming correspondence between your office and WPS, while the patient becomes increasingly worried about the delay in payment. Clearly, anything that can be done at the start to facilitate claims processing is worth emphasizing. Therefore, here are a few suggestions which may seem very obvious but which, if consistently followed, will save needless correspondence in the long run.

First, whether or not you file on a standard WPS claim form, if you are sending a bill, WPS needs an itemized statement in order to process it. An itemized statement includes the date of service, description of service, charge for each service provided and, when appropriate, a diagnosis for the service or services. It is surprising how many claims are delayed in process because one or more of the above items is missing.

The diagnosis should be as complete as possible because, under some WPS contracts, payment may be approved for a service with one diagnosis but denied for the same service with another diagnosis. This is especially the case when medical treatment is administered in a hospital emergency room. Most WPS policies are specific about circumstances under which emergency room treatment is a payable benefit, and an incomplete diagnosis may precipitate an incorrect denial of benefits.

Second, along with the usual personal information, be sure to include the patient's subscriber or identification number. Policyholder records at WPS are accessible through the identification number and not the name. Therefore, a claim on which WPS cannot locate the policy number cannot be processed. Time is saved if you obtain the patient's subscriber number from the identification card at the time the service is provided and include it on your statement, double-checking to make sure the number is copied correctly.

Also important is making sure that the physician's 5 digit WPS provider number is included and correct on the claim statement, along with the name and address of the physician's office. WPS makes payments directly to the physician's office on the basis of the physician's provider number--the number assigned a physician or a physician's office by WPS. Payment may be delayed or may not be made at all if this provider number is incorrect or missing.

If you ever contact WPS regarding the status of a claim you have filed, be sure to have the above necessary information in your inquiry. If you telephone WPS, simply give the relevant claims information to the correspondent to whom you talk. If you write WPS, a convenient format would be to send an exact copy of the claim along with a short note with your questions. If for some reason WPS never received your original claim, the copy can be processed just as easily.

Following these guidelines will insure that claims filed with WPS are processed promptly, accurately, and efficiently--necessarily a concern of foremost priority for the patient, the physician's office, and WPS.

If you have any questions or comments on "Report," sent them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 30¢ per word, with a minimum charge of $12.00 per ad. BOXED AD RATES: $15.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

Physicians Exchange

PHYSICIAN(S) INTERESTED IN family practice to locate in Baldwin, Wis. Excellent hospital facilities located adjacent to Clinic. Offers excellent family environment and a variety of recreational activities. 40 minutes east of St Paul, Minn. Contact Gordon Palmer. Admin, Baldwin Community Hospital, Baldwin, Wis 54002. Tel: collect 715/684-3311. 10-12/79

GONZALEZ MEDICAL CENTER is seeking a pediatrician who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, telephone 414/344-1120; 414/671-5410; 414/476-8624. 8-12/79, 1/80

THE WAUSAU MEDICAL CENter, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Dermatology
- Orthopedics
- Otolaryngology
- Radiology (2)

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, wirte John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 8tfn/79

WANTED — VOLUNTEER PHYsician to work at free VD clinic on Milwaukee's lower eastside with primarily a gay clientle. Six hours per month. Contact: Medical Director, VD Clinic, Farwell Center, 1568 North Farwell, Milwaukee, Wis 53202. 10-11/79

OB-GYN: IMMEDIATE OPENing with 8-man, multispecialty group. To join present Ob-Gyn, four internists, two pediatricians, and general surgeon. Clinic building next door to community hospital. Good recreational facilities available. Western Milwaukee metro fringe location. First year salary with optional second year corporate stockholder. Excellent fringe benefits including profit-sharing—pension plan. Young group. Contact James L Algiers, MD or Clinic Manager, Parkview Medical Associates, Ltd, 1004 East Sumner St, Hartford, WI 53027. Tel: 414/673-5745 (collect). 5tfn/79

MULTISPECIALTY GROUP OF 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Dermatologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

MILWAUKEE HMO—2 FAMILY physicians needed for innovative group practice. New multi-million dollar facility with full support services located in the suburb of Greenfield. Present staff includes four family practitioners, a physician's assistant and a nurse practitioner. Congenial atmosphere, four day week, light call. Attractive salary and fringe benefits. Contact Philip Eckstrom, MD, Family Health Plan, 6901 W Edgerton Ave, Milwaukee, Wis 53220. Tel: 414/421-8400. 9-11/79

WANTED: PHYSICIAN TO JOIN group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Marie Olson, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

FAMILY PRACTICE AVAILABLE for one or two physicians. Thirty-year practice established by my father. Excellent accredited hospital facilities located in Menomonee Falls, Wis. Only ten miles from Milwaukee County Medical Complex. Area offers good school and recreational facilities for family. Write: Mrs Howard F Schloemer, PO Box 307, Menomonee Falls, Wis 53051. Tel: 414/251-5655. p11/79

RURAL MULTISPECIALTY CLINic located in Central Wisconsin invites resumes from residency trained physicians in emergency medicine. Guaranteed income plus full fringe benefits. New hospital and clinic complex. Opportunities for teaching. Contact Dr Sidney E Johnson, Medical Director, Marshfield Clinic, Marshfield, Wis 54449. 11-12/79

ANESTHESIOLOGIST AVAILABLE for relocation. Mid-40s, Board certified, Wisconsin license. Will consider smaller cities. Write Dept 474 in care of the Journal. p11-12,1/80

Physicians Exchange

continued

WANTED: FAMILY PRACTICE physician to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

FAMILY OR GENERAL PRACtitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

GENERAL INTERNIST WITH GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info: J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

RADIOLOGIST — BOARD CERtified is needed to become the fifth associate in an active radiology practice. One or two years experience desirable. Call 715/842-0624, or write W Mahony, MD, Radiology Associates of Wausau, SC, 425 Pine Ridge Blvd, Wausau, Wis 54401. 6tfn/79

ALGOMA CLINIC NEEDS ANother doctor. Please contact J F March, MD, 413 Fourth St, Algoma, Wis 54201. 10tfn/79

BOARD CERTIFIED OB/gyn to work part time in outpatient women's clinic located in Madison, Wisconsin. Work involves performing trimester abortions and diagnostic pelvic examinations. Please call 1/414-289-9900 or write to: Summit Medical Center, 606 W Wisconsin Ave, Milwaukee, Wis 53203, attention Director. 11/79

FAMILY PHYSICIAN: APPLEton, Wis, to join four certified ABFP physicians. City of 60,000—economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact: K E Buchanan, MD, 620 E Longview, Appleton, Wis 54911. Tel: 414/734-7144. 9-11/79

WANTED: GENERAL PRACTItioner to join well established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Rose-Jensen-Manabat, 621 E Walnut St, Green Bay, Wis 54301. Tel: 414/437-4366. 10-12/79

WANTED: OSHKOSH, WIS. CAreer Emergency Physician, fulltime. Experienced, residency training preferred. ACEP. New ED facilities. Paramedic program. 45-hour week, competitive salary, generous fringes including malpractice, corporate paid retirement plan, CME allowance. Send CV to Thomas Loescher, MD, 2520 Crestview Drive, Appleton, Wis 54911. 10-11/79

OB-GYN SPECIALISTS DESIRED. Enjoy the security of group practice with the freedom of independent practice. If you are Board certified or Board eligible in OB-GYN, we have an interesting opportunity for you. One or two specialists are needed immediately to form an independent OB-GYN practice in a very desirable Northern Wisconsin community with a drawing population of 65,000. Active practice assured. All major specialists available for consultation. Business advice, technical and legal, will be provided. Outstanding personal benefit programs available. Income potential great. Generous starting income guaranteed. A 35 million dollar hospital just opened with available office space. For further information call 715/842-3202, or write Mr Lloyd Engstrom, PO Box 1646, Wausau, Wis 54401. 10tfn/79

PSYCHIATRIST—MEDICAL DIrector for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

EXPERIENCED GENERAL SURgeon needed to join two general internists, a gastroenterologist, four family practitioners, and a pediatrician in a busy satellite of the Marshfield Clinic at Ladysmith, Wis. Complete details and personal interview will be arranged for qualified applicants. Send curriculum vitae, bibliography, and three references to William M Toyama, MD, Department of Surgery, Marshfield Clinic, 1000 N Oak Ave, Marshfield, Wisconsin 54449. 11-12/79

BOARD CERTIFIED OR ELIGIble primary care internists and family practitioners wanted for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel:414/289-5910. 9-12/79

WANTED: ORTHOPEDIC SURgeon to practice with one other orthopedic surgeon, multispecialty clinic, primary care oriented with 13 MDs. New hospital immediately adjacent to clinic. 65 miles from Minneapolis/St Paul on I-94. Ideal situation for family-oriented lifestyle. Recreation, time off, congenial group. Rapidly growing college community. No seniority and full status after one year. Competitive salary first year. Contact Rex Shaffer, Manager, or Dr James Haemmerle. Call collect 715/235-9671, or write Red Cedar Clinic, 2211 Stout Road, Menomonie, Wis 54751. 7-12/79

GREEN BAY, WISCONSIN—AN excellent opportunity is available for a family practice physician in the Green Bay, Wisconsin area. A younger family practice resident, or general practitioner with some experience is desired. New office setting is in close proximity of a family practice oriented hospital facility. Association and practice arrangements flexible. Contact: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. p11-12/79

FAMILY PRACTICE, ENT AND Internal Medicine positions available with a 15-man multispecialty group corporate practice. Modern clinic facility in northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 8-11/79

WISCONSIN — FAMILY PRACtice physician wanted, incorporated clinic group of five, including Family Practice and General Surgery. Ideal town in northern Wisconsin, 35 miles from Minneapolis. Income guaranteed first year. Contact J Craig, New Richmond Clinic, SC, New Richmond, Wis 54017 (715)/246-6911). 7-11/79

NEUROLOGISTS: BOARD ELIgible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG. Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

GROUP HEALTH COOPERATIVE of south Central Wisconsin. A growing federally qualified staff model HMO—is recruiting family practitioners for January 1980. Excellent salary, pension and benefit program in an area of natural beauty make living and working here very attractive. Write or call David S Grab, MD, Medical Director, 1 South Park St, Madison, Wis. Phone 608/257-9700. An Equal Opportunity Employer. 7-12/79

RACINE MEDICAL CLINIC, SC, multispecialty group of 18 physicians has a practice association for

- Internist
- Obstetrician-Gynecologist
- Family/General Practitioner

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 7tfn/79

INTERNIST—THIS IS A FINE opportunity to join a five-man, well established, internal medicine group with both downtown Milwaukee and suburban offices for someone either in solo practice or completing residency. Excellent starting salary, fringe benefits, hospital associations, and teaching appointments. Please send curriculum vitae to Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 8-11/79

FAMILY PRACTITIONER wanted for rural area in NW Wisconsin, town of 2500, service area includes 25,000 patients. Joint four ABFP and one Board certified surgeon in a growing family oriented group practice. Excellent salary and benefits. New large clinic building ready for occupancy June 1, 1980, close to JCAH approved hospital. The service area is one of the most desirable living areas in Wisconsin with unlimited outdoor recreation available. Contact: Paul G Goellner, MD, Spooner Clinic Ltd, Spooner, Wis 54801. Tel: 715/635-2151. 10-12/79, 1/80

FAMILY PRACTICE — SOUTHeast. Private practice opportunity group or solo in medium-size city with new 150-bed hospital. Present medical staff of 24 with three FPs age 64. Attractive office space and complete financial assistance package. Family oriented stable community. Curriculum vitae in confidence to: Mr William Anderson, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Ga 30338. p10-12/79

ORTHOPEDIC SURGEON BOARD certified or eligible to join established orthopedic surgeon in midwest town of 90,000. Salary negotiable. Interested parties should contact Dept 473 in care of the Journal. p11/79

FAMILY PRACTITIONERS. Good opportunity for one or two family practice physicians to join a well established three-man clinic (includes surgeon). Present staff leases modern, up-to-date, ten-year old clinic from city. Unlimited potential in a setting suited for aggressive, progressive physicians like yourself. JCAH hospital physically attached to 175-bed nursing facility. Receiving consultant specialty visitation services via the University of Minnesota in areas of Otolaryngology, Pulmonary Medicine, Neurology, Cardiology, Urology, and Internal Medicine. Located in heart of state's finest goose hunting area, fishing and lake cabin life a stone's throw away. Good schools; quiet community, with slow pace of living that includes our own cultural affairs building for staging local drama and musical activities. Are you interested enough to find out more about us? If so, contact Mr Richard L Range, Admin, Madison Hospital Association, 820 Third Ave, PO Box 184, Madison, Minnesota 56256, or call collect 612/598-7556 (office) or 612/598-7974 (home). 9-11/79

PEDIATRICIAN TO JOIN 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

THE MIDELFORT CLINIC IS seeking associates in the following areas:

- Family Practice
- Cardiology
- Allergy

This is an opportunity to affiliate with a 48 member group located in a college community of 50,000. Satellite practice locations also available. Contact G E Owen, MD, Midelfort Clinic, Ltd, Eau Claire, Wis 54701 or call 715/839-5222. 10-12/79

TWO FAMILY PRACTICE PHYSIcians to join or associate with multispecialty group in satellite setting in semi-rural community 30 miles north of Milwaukee in beautiful Kettle Moraine. Financial arrangements, benefits, and practice opportunity exceptional. Contact Executive Director, Hartford Memorial Hospital Foundation. Tel: 414/673-2300 (collect) 11-12/79,1/79

RADIOLOGIST: POSITION AVAILABLE

7/1/80 for Board eligible or certified physician to join active radiology practice with group of four in private office and two general hospitals. Contact R E Zellmer, MD, 2500 N Mayfair Rd, Suite 201-203, Milwaukee, Wis 53226. Tel: 414/476-4242. 10-11/79

THE BELOIT CLINIC, A GROWing 28 physician multispecialty group, in cooperation with the Village of Clinton, Wisconsin, will be establishing a satellite facility. Two Board Certified/Board Eligible family practitioners are invited to share in the organization of this challenging project in this desirable location. Very competitive income and membership in the Beloit Clinic, and privileges in Beloit Memorial Hospital would allow the practice of primary care with the advantages of group practice. For further details write Ken Gold, MD, 1905 Huebbe Parkway, Beloit, Wis 53511. 10-11/79

FAMILY PRACTITIONER TO join three man group. Central Wisconsin community of 10,000 with drawing area of 20,000. Hundred bed accredited hospital. Handsome salary first year with many fringe benefits, full partnership second year. Send curriculum vitae to Merrill Medical Associates, SC, 716 East Second St, Merrill, Wis 54452. Tel: 715/536-2463. 10-12/79

NEUROLOGIST WANTED — Clinical Neurologist wanted to practice in conjunction with a 6-member Internal Medicine Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 470 in care of the Journal. 9tfn/79

OB-GYN WANTED — TO PRACtice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency

9tfn/79

Physicians Exchange

continued

FIFTY-MAN MULTISPECIALTY group has an immediate opening for:
- Orthopedic Surgeon
- Ophthalmologist
- Family Practice
- Psychiatrist

Excellent starting salaries with all fringe benefits. Monroe is a very stable economically-strong community of 10,000 located 45 minutes from Madison and 90 minutes from Milwaukee. If interested, please contact T E Peters, MD, The Monroe Clinic, Monroe, Wis 53566. 9-12/79, 1-2/80

Medical Facilities

SPACE AVAILABLE IN WESTwood professional building, Delafield, Wis. 2000 sq ft on ground level; design your own floor plan. Easy access to 1-94. Oconomowoc Memorial is just 10 minutes away. Negotiable lease. Call 414/276-0431 or 414/646-2340. 11tfn/79

PROSPECT BUILDING. SEVERAL medical suites now available, including custom plumbing and examining rooms. Utilities and janitorial service included in base rental of $6.50 per square foot. Undercover parking for tenants and visitors. Ideally located at North and Prospect, Milwaukee. Call 414/278-7511. p11-12/79

FOND DU LAC FACILITY. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

FOR SALE — TWO PHYSIOtherapy adult examining tables. Upholstered, brown vinyl cover, paper dispensers, pillows, walnut. No scratches or blemishes — mint condition. List at $225 each, asking $100 each. Tel: 414/278-3621. 10-11/79

Advertisers

Acme Laboratories 35
Air Force Medical Opportunities 23
Answer Madison Telephone Secretaries Inc 13
Burroughs Wellcome Co 28, 50
Empirin® c Codeine
Zyloprim®
Dista Products Co (Div of Eli Lilly & Co) ..... FC
Nalfon®
Douglass China & Galleries Ltd 13
Health Information Systems, Inc 60
House of Bidwell, Inc 50
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Smith Kline & French 45, 64
Tagamet®
Hemoccult®
Upjohn Company, The 19, 20, 21, 22
Motrin®

Bookshelf

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Corporate Stress. By Rosalind Forbes, EdD. Publicity Department, Doubleday & Company, Inc 245 Park Ave, New York, NY 10017. 1979. Pp 201. Price: $4.95.

Family Health and Home Nursing. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. Pp 625. Price: $3.95.

Life Stress. By Rosalind Forbes, EdD. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 166. Price: $3.95.

Dr Fishbein's Popular Illustrated Medical Encyclopedia. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 773. Price: $14.95.

Pregnancy Metabolism, Diabetes and the Fetus. Ciba Foundation Symposium 63. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, New Jersey 07901. 1979. Pp 322.

Physician Distribution and Medical Licensure in the U S 1977. Center for Health Services Research and Development, American Medical Association, Box 821, Monroe, WI 53566. Pp 622.

Clinical Cardiology. By Maurice Sokolow, MD and Malcolm B McIlroy, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1979. Pp 718. Price: $17.50.

Review of Physiological Chemistry. By Harold A Harper, PhD; Victor W Rodwell, PhD; Peter A Mayes, PhD, DSc. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1979. Pp 702. Price: $14.50.

The Courage to Live. By Ari Kiev, MD. Thomas Y Crowell, Publishers, 10 E 53rd St, New York, NY 10022. 1979. Pp 147. Price: $7.95.

Brain Surgeon. By Lawrence Shainberg. J B Lippincott Company, New York. 1979. Pp 276. Price: $10.95.

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1979 Wisconsin

Dec 3-4: Review course for American College of Physicians' Medical Knowledge Self-Assessment Program V (MKSAP V), at The Abbey on Lake Geneva, Fontana, Wisconsin. This Milwaukee course (No A07) deals with allergy and immunology, endocrinology and metabolism, oncology. Physicians who attend it can earn 12 credit hours in Category I of PRA-AMA. Course codirectors are: Charles L Junkerman, MD, FACP, Governor for Wisconsin (ACP), professor of medicine, Medical College of Wisconsin, Milwaukee, and David Graham, MD, FACP, professor of medicine, MCW, Milwaukee. Additional information about MKSAP V courses is available from the ACP, 4200 Pine St, Philadelphia, Pa 19104 (215/243-1200).

Dec 5: *Sexuality and the Older Citizen*, at University of Wisconsin-Green Bay, Community Science Building. For healthcare professionals working in the healthcare field, with emphasis on the older citizen. Fee: $40. Presented by University of Wisconsin-Extension, Departments of Continuing Medical Education, Continuing Education in Nursing, and Extension Services in Pharmacy; and University of Wisconsin-Madison, School of Medicine.

Dec 7: *Nutrition in Cancer Conference*, UW Clinical Science Center, Madison. Sponsored by Wisconsin Clinical Cancer Center. See details in box elsewhere in this section.

GREAT LAKES SKI-IN: SURVIVAL IN EMERGENCY MEDICINE

A course on Management, Legal and Financial Aspects of EM and EMS Impact

Playboy Club, Lake Geneva, Wis
February 18, 1980

Sponsored by Wisconsin Chapter, American College of Emergency Physicians

8 hours Category I credit of ACEP/AMA and AAFP. Fee: $85-$100.

Info: J Gennrich, MD, Wisconsin ACEP, 10201 W Lincoln Ave, Milwaukee, Wis 53227. Tel: 414/545-5568.

DSM III: A WORKSHOP WITH THE ARCHITECTS

January 10, 1980

Wisconsin Center, Madison, Wisconsin

Audience: Psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, medical records personnel and other health care personnel who will be using manual.

Fee: $60.00

Subject: Introduction to the *Diagnostic and Statistical Manual III* which will be the standard psychiatric classification in the US on January 1, 1980.

Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706

1980 Wisconsin

Jan 3-9: 13th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics and Endocrinology*, at Pfister Hotel and Tower in Milwaukee. Six-day course extended to include a complete up-to-date review of endocrinology and cytogenetics in addition to a thorough resume of gynecological pathology. Designed primarily as a postgraduate refresher course for residents, practitioners, and specialists desiring a current review of the pathology and the reproductive tract. Guest faculty: H W Jones, MD;

10th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

Sponsored by the Department of Family Practice, The Medical College of Wisconsin and Southeastern Chapter of the Wisconsin Academy of Family Physicians

Jan 16, 17, 18, 1980

The Pfister Hotel and Tower
Milwaukee, Wisconsin

Approved 20 credit hours in Category I for PRA-AMA and AAFP

Course Director: *John L Raschbacher, MD*, Associate Professor of Family Practice, Program Director, Family Practice Residency Program, Waukesha Memorial Hospital

Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, WI 53211. Tel: 414/291-0813

1980 Wisconsin

continued

Georgeanna S Jones, MD; J D Woodruff, MD; and Conrad Julian, MD. Space limitation requires registration for the entire course which is limited to 150 registrants. Approved for 55 cognate hours of prescribed credit by ACOG and meets criteria for 43 hours of credit in Category 1 for the PRA-AMA. A $450 enrollment fee will include 68 selected 35mm slides. Registration fee is nonrefundable. Info: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, Medical College of Wisconsin, 8700 West Wisconsin Ave. Milwaukee, Wis 53226; phone 414/257-8200.

Jan 10: *DSM III: A Workshop With the Architects.* Wisconsin Center, Madison. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706. (Further details elsewhere in this section)

Jan 16-18: *10th Annual Winter Refresher Course for Family Physicians.* The Pfister Hotel and Tower, Milwaukee. Info: Mrs Susanna Rechlitz, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, WI 53211. Tel: 414/291-0813. (Further details elsewhere in this section)

Jan 16: *Geriatric Medicine.* St Mary's Hospital Medical Center, 707 South Mills St, Madison. Approved 4 hours prescribed credit AAFP and Category 1 PRA-AMA. Details elsewhere in this section.

Feb 18: *Great Lakes Ski-In: Survival in Emergency Medicine.* Playboy Club, Lake Geneva. Info: J Gennrich, MD, Wisconsin ACEP, 10201 W Lincoln Ave, Milwaukee 53227. Tel: 414/545-5568

Feb 21: *A Day of Cardiology.* Methodist Hospital, 309 W Washington Ave, Madison. Approved 4 hours prescribed credit AAFP and Category 1 PRA-AMA. Details elsewhere in this section.

Mar 12: *A Day of Cancer, Prevention and Therapy.* UW Center for Health Sciences, 600 N Highland Ave, Madison. Approved 4½ hours prescribed credit AAFP and Category 1 PRA-AMA. Details elsewhere in this section.

Nutrition in Cancer Conference

Friday, Dec 7

University of Wisconsin
Clinical Science Center
Auditorium G5/119
600 Highland Ave, Madison

Sponsored by UW Clinical Cancer Center

FOR PHYSICIANS—

Medical Oncologists, Surgical Oncologists, Other Interested Physicians

FOR NURSES—

Nurse Clinicians, Other Interested Nurses

FOR DIETITIANS—

Hospital Dietitians

To expand the understanding and appreciation of nutritional support of the cancer patient as a team activity

SPEAKERS—

See list in adjacent column

TOPICS—

- Cancer Malnourishment and Nutritional Evaluation
- Nutritional Impact on the Immunologic Evaluation of Cancer Patients
- Clinical Enteral Nutritional Support of Cancer Patients
- Vitamins and Cancer
- Hormones and Cancer
- Amino Acids
- Panel: Nutritional Needs of the Cancer Patient . . . from the view of the—
  Nurse
  Dietitian
  Practicing Physician

CME information: 5 credit hours in Category 1 of PRA-AMA; 5 prescribed hours by AAFP; 5 hours by American Dietetic Association

PROGRAM PLANNING COMMITTEE—

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—Paul C Tracy, MD
—William T Russell, MD

For further information call: David C Reynolds (608) 263-6947

Speakers for the Conference on Nutrition in Cancer

- **Donna Becker, RD, MS**
  Assistant Director of Clinical Dietetics, UW Hospital and Clinics, Madison
- **Albert E Bothe Jr, MD**
  Clinical Instructor in Surgery, Harvard Medical School, Cambridge
- **Raymond R Brown, PhD**
  Professor of Human Oncology, UW Center for Health Sciences, Madison
- **Paul P Carbone, MD**
  Professor and Chairman, Dept of Human Oncology; Director of the Wisconsin Clinical Cancer Center, UW Center for Health Sciences, Madison
- **John M Daly, MD**
  Assistant Professor of Surgery, University of Texas, MD Anderson Hospital and Tumor Institute, Houston
- **Tom R DeMeester, MD**
  Associate Professor, Dept of Surgery, University of Chicago
- **Alfred E Harper, PhD**
  Chairman of Nutritional Sciences University of Wisconsin-Madison
- **David P Rose, MD**
  Professor in the Dept of Human Oncology, UW Center for Health Sciences, Madison
- **Josh C Tunca, MD**
  Assistant Professor, Division of Gynecologic Oncology, UW Center for Health Sciences, Madison
- **Saundra E Saunders, RN, MSN, MEd**
  Clinical Nurse Specialist—Gynecologic Oncology, UW Center for Health Sciences, Madison

See further details of the conference in adjacent column

Aspen Seminar
for healthcare providers and their legal counsel

ANTITRUST AND HEALTH CARE

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February 13-15, 1980

Hyatt Lake Tahoe

SEMINAR OUTLINE: Introduction to Antitrust Law; Introduction to Antitrust Enforcement; Medical Staffs; Hospital Mergers and Consolidations; MultiInstitutional Ventures; Participation in the Regulatory Process; Private Planning; Professional Codes of Ethics; Accreditation and Licensure; Third-Party Providers and Payors.

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SEMINAR FEE INFO: Two and one-half days. Tuition: $350 (single registrant). Two or more from same institution $310 per registrant.

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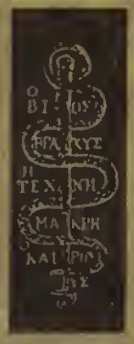

THE CHARITABLE EDUCATIONAL AND SCIENTIFIC FOUNDATION OF THE

STATE MEDICAL SOCIETY OF WISCONSIN

State Medical Society of Wisconsin presents

1979-1980 Madison Seminars For Physicians

Thursday, December 13, 1979; Wednesday, January 16, 1980; Thursday, February 21, 1980; Wednesday, March 13, 1980

Faculty provided by: Madison General Hospital, Methodist Hospital, St Mary's Hospital Medical Center, UW Center for Health Sciences

Cosponsors: Madison Chapter, Wisconsin Academy of Family Physicians—Postgraduate Program, Merck Sharp & Dohme

---

Thursday, Dec 13: Madison General Hospital. Two programs are being offered this date; one (Group A) on New Standards for Cardiopulmonary Resuscitation, the second (Group B) on Emergency Treatment. NOTE: If you attend Group A (CPR) there will be an additional charge of $20. The CPR course is limited to 32 physicians!

GROUP A: *New Standards for Cardiopulmonary Resuscitation* (Certification in the American Heart Association) 8:30 - 4:30: Overview of Basic Course, *Joe Ketarkus,* RN; Film-New Pulse of Life-Revised; Demonstration of Performance Areas of Basic Life Support, *Joe Ketarkus, RN*

GROUP B: **Emergency Treatment.** 9:30 - 3:00. Emergency Management of the Multiply Injured Patient; Evaluation of the Sexually Assaulted Patient, *Kurt Martyn, MD;* An Approach to Overdose Management, *Kenneth L Bussan, MD;* Acute Respiratory Emergencies, *Mark H Katz, MD;* Emergency Management of Accidental Hypothermia, *Melvyn A Pearlman, MD*

CPR Course, 6 hours prescribed AAFP; 6 hours Category 1 for PRA-AMA; Emergency treatment, 4 hour prescribed AAFP; 4 hours Category 1 for PRA-AMA

* * *

Wednesday, Jan 16: St Mary's Hospital Medical Center. **Geriatric Medicine.** 9:00 - 3:00. Problems of Laboratory Diagnosis in the Elderly, *William H Card, MD;* Cardiac Drugs in the Elderly, *Kay M Barrett, MD;* Psychiatric Problems and Management in the Elderly, *Stanley Miezio, MD;* Estrogen and the Female Climacteric, *Karl A Rudat, MD*

Approved 4 hours prescribed AAFP; 4 hours Category 1 for PRA-AMA

* * *

Thursday, Feb 21: Methodist Hospital. **A Day of Cardiology.** 9:00 - 3:00. Pacemakers—Who Needs 'Em, Why, and When, *John Morledge, MD* and *Leslie Katzman, RN, RCPT;* Nuclear Cardiac Imaging-Practical Applications, *Peter Rank, MD;* Current Status of Coronary Artery Surgery, *D John Farnham, MD* and *E Adib, MD;* Cardiac Rehabilitation in the Community, *A J Pois, MD; Catherine Budd, RN, MS; Bill McGrath, Vocational Counselor*

Approved 4 hours prescribed AAFP; 4 hours Category 1 for PRA-AMA

* * *

Wednesday, Mar 12: UW Center for Health Sciences. **A Day of Cancer Prevention and Therapy.** 8:30 - 2:30. Adjuvant Therapy, *Paul P Carbone, MD;* High Risk Patients and Cancer Prevention, *Richard R Love, MD* and/or *Anthony E Camilli, MD;* Prostate Cancer, *Ralph C Benson, MD;* Use of Nuclear Medicine in Cancer, *Dennis L Citrin, MB, ChB, PhD*

Approved 4½ hours prescribed AAFP; 4½ hours Category 1 for PRA-AMA

REGISTRATION FEE: (Including lunch) $50 for members of SMS, WAFP, WAOP&S with attendance at Emergency Treatment Dec 13; and $70 with attendance at CPR course Dec 13. Individual Meetings $15 each EXCEPT Dec 13, $35, if attending CPR course. Non-members SMS, WAFP, WAOP&S entire series $80 with attendance at Emergency Treatment Dec 13. Entire series $100 with attendance at CPR Dec 13. Individual Meetings $25 each EXCEPT for Dec 13, $45 if attending CPR course that date. Make check payable to: CES Foundation, and mail to CES Foundation, PO Box 1109, Madison, Wis 53701

Pre-registration recommended

For information contact:

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Scientific Affairs Coordinator

or

Arlene Meyer

Administrative Assistant for Continuing Medical Education

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or
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(toll-free)

This program is a membership service of the State Medical Society of Wisconsin

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

EQUITY ADJUSTMENTS IN MEDICARE PROFILES. The Medicare charge profile forms the basis for payments for MD services to both Medicare and Medicaid patients. Thus, it is important that physicians know their profile and its accuracy. That profile is created and maintained by the Medicare intermediary (in Wisconsin it is WPS) under federal guidelines. Any physician can request his/her Medicare profile (individual customary charge data) as well as the area prevailing charge profile for his specialty. This can be done annually after the carrier has established the customary charge screens for a particular fiscal year. (July 1 begins the fiscal year for Medicare carriers.)

If a physician feels that an error has been made in the customary charge screen, a request for consideration of an equity adjustment can be made of the intermediary. Request for revision in a customary charge profile can be initiated only by the physician whose services are being profiled.

The following information must be provided to initiate consideration of an equity adjustment.

1) Identification of the particular situation for which an equity adjustment is requested.
2) The time that has elapsed since the last change was made in the customary charges.
3) The size of the requested increase and the relationship of the new and old charges to charges made by others for the service.
4) The increases in the physician's operating expenses which are used to justify an increase in charge.
5) The achievement of "Board Certified" specialty status.

All statements regarding the equity increase should be specific, and when possible, documented. A request for consideration for equity adjustment for Wisconsin physicians should be made to: Utilization Review/Advisory Section, WPS Medicare Department, Box 1787, Madison, Wisconsin 53701.

If a physician wishes State Medical Society advice or assistance on this matter, contact Marge May, Physicians Alliance Division, in Madison (Madison area: 257-6781; or toll-free: 1-800-362-9080).

FTC RULING GOES BEYOND ADVERTISING. The Federal Trade Commission ruling of October 24 was widely publicized by the media as barring AMA from considering advertising by physicians as unethical. AMA does not consider advertising unethical if it is not misleading, false, or deceptive. Of greater concern is that FTC has said that AMA may not enforce ethical guidelines on fee-splitting with nonmedical persons, and it may not consider "inducements" as unethical. These aspects of the FTC rule are being appealed by AMA.

SLOW TAXPAYERS TAKE NOTE. On Feb 1, 1980 the interest rate charged by the Internal Revenue Service will double, going from 6% to 12% per annum. This will apply to interest assessed on late federal income tax payments and on additional taxes resulting from federal tax audit adjustments. Uncle Sam will no longer be a cheap source of funds for slow taxpayers. ■

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WISCONSIN MEDICAL JOURNAL

DECEMBER 1979

• Lumbar disc disease: series of nine articles • President Treffert defends membership dues • Resolution deadline: January 25 • New medical protection plan for members • Psychotherapy provisions delay endorsement of SuperRule • Legislative scoreboard • Index to Volume 78 of *Wisconsin Medical Journal*

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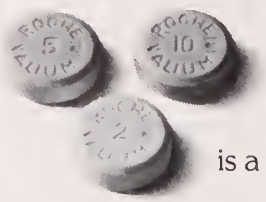
A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

STATE MEDICAL SOCIETY OF WISCONSIN

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Created by the Territorial Legislature in 1841

Representing 4,700 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* the official publication of the Society.

Editorials

Editorial Director: WAYNE J BOULANGER, MD

Lumbar disc disease

THE ENTIRE scientific section of the December issue of the *Wisconsin Medical Journal* is devoted to lumbar disc diseases. This series of nine papers was conceived and coordinated by Dr Glenn A Meyer of the Department of Neurosurgery at the Medical College of Wisconsin.

The several authors approached the subject of lumbar disc disease from the standpoint of neurosurgeons, physiatrists, orthopedic surgeons, neurologists, radiologists, and anesthesiologists. Thus, therapy for this condition is covered in a wide range from conservative to operative.

The *Wisconsin Medical Journal* Editorial Board and staff are indebted to Doctor Meyer and his colleagues for presenting this symposium for our readers.—VSF

Cost containment

A RECENT UPI release reports that Rosalynn Carter's personal staff is the largest ever organized by a president's wife. This staff consists of 21 full-time permanent employees costing the taxpayers $650,000 a year. One person earns $56,000, the same amount paid to the President's National Security Advisor and also to his Chief of Staff. The article also pointed out that these aides map out her travels and promote the Carter image.

Presidential aspirant Kennedy has a full-time staff of 120. This group of advisors includes one physician who is obviously not practicing medicine. Although senatorial prerogatives legitimately include an adequate staff of advisors, certainly some of this group must also be advising and counseling on the political front. The Senator would require a considerable staff to produce his complicated extravagant healthcare bill. The *Wall Street Journal* points out that his healthcare bill is immensely detailed and the table of contents alone covers five single-spaced pages. However, in eight years not one of Mr Kennedy's healthcare bills has ever moved out of a single committee.

The *Wall Street Journal* article further points out that there is some confusion in that Senator Kennedy is engrossed with deregulation in which he wants to get the government out of people's way as he has with the airlines and proposes to do with the deregulation of the trucking industry. What is confusing is that simultaneously he has an opposite position in healthcare in which he wants even more government involvement in people's lives.

The AMA has appeared before Congress and has pleaded that scarce Federal dollars should be spent to provide services for people with serious mental illness rather than to maintain planners, statisticians, and administrators. It is these latter groups who are progressively becoming more involved in dictating how physicians should go about practicing medicine.

It is a strange two-way stretch when we in the medical field are constantly harangued about cost containment, and the lecturers in Washington certainly are not practicing what they are preaching.—VSF

Pot cult

A SEGMENT of a recent TV documentary program presented the bizarre spectacle of a pseudo-religious cult that seemed to be based entirely on pot smoking. This strange and apparently affluent collection of robed and bearded persons has established their strange sect by lifting a verse out of context from the Bible.

A most distressing aspect of the program was seeing the little children participating in the ritual of pot smoking. One wonders what other educational advantages these sorry youngsters have.

Can you imagine what the response of this group of potheads would be in a time of a true national emergency?—VSF

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Are you ready?

WITHOUT CHOOSING UP sides with the doves or hawks, it is becoming increasingly obvious that the number of unfriendly footholds in the western hemisphere is increasing.

A dedicated hawk like retired Marine General Louis W Walt is convinced that this country will be in real trouble within three to five years.

Should a major confrontation occur, it could be much closer to home for the first time since 1812. We would not have the advantage of having an empire such as Britain holding the fort for us as they did early in World War II while this country tooled up after Pearl Harbor.

What does this have to do with medicine or a medical journal? The question is, is this country in any way medically prepared to cope with truly mass casualties? By their own admissions, the Surgeons General have woefully inadequate medical coverage for the present relatively small Armed Forces.

Ready or not, it could happen here! —VSF

COMMENT: One reason the shortage of medical officers exists is that the Armed Forces require retirement at age 60, a productive age, rather than age 62 (enlisted personnel), or age 70, the mandatory retirement age for the overall population. Civil Defense organizations are fine, but not enough for an all-out catastrophe, especially one involving thermonuclear weapons.—HML ■

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J9AR13

Letters

Expanding role of mammography

WE CANNOT let the article appearing in *Wisconsin Medical Journal,* August 1979, under Cancer Column pass without comment. Although we agree with the author, Dr Matallana, regarding the necessity of close clinical correlation with mammography, we do object to the allusion that ultrasound and galactography are routinely used in the diagnosis of breast diseases. Additionally the pneumocystogram, although easily done, in our view is best characterized as superfluous.

A patient presenting with a "significant breast mass" regardless of its roentgenologic appearance if considered by the surgeon as being dominant needs aspiration, and if solid an open biopsy. If this "significant mass" is cystic and completely resolves with aspiration, assuming the cytology is innocuous, then observation is all that is indicated. If the cystic fluid is bloody, however, open biopsy is mandatory.

As for the clinically occult lesion the size of which is generally directly related to the size of the breast, needle localization can be easily performed and thereby the area of roentgenologic concern can be sampled with subsequent minimal loss of breast substance and deformity of the breast.

The patient that presents with nipple discharge, particularly of recent onset and bloody in nature, is obviously a concern. The majority of these will ultimately be related to intraductal papillomata. No amount of radiologic maneuvers will distinguish the intraductal papilloma from the small intraductal papillary carcinoma. In this setting it is our feeling that selective excision of the duct involved be performed.

We object to the concept of others not responsible for the surgical care of these patients needling lesions of the breasts, as well as placing needles for localization in the breast. We subscribe to the team approach and would prefer that the surgeon be involved with such maneuvers, so that the placement at the skin level does not jeopardize subsequent mastectomy flaps, and so that underlying tissues are not potentially contaminated by inadvertent penetration of the underlying pectoral fascia and muscle. By close cooperation among the modalities involved, optimal care can be achieved.

—**James L Hoehn, MD,** Dept of General Surgery
—**Gail H Williams, MD,** Dept of General Surgery
—**Jerry M Hardacre, MD,** Dept of General Surgery
—**Roberto Cantillo, MD,** Dept of Medical Oncology
—**Thomas D Hinke, MD,** Dept of Radiology
—**Robert H Greenlaw, MD,** Dept of Clinical Oncology
Marshfield Clinic, Marshfield, Wisconsin

Complaint brochure praised

I want to congratulate Secretary Earl Thayer, his staff, and all the physicians who were responsible for putting together the brochure "If You Have a Complaint About Medical Care." It is one of the best examples of good public service and education SMS has ever produced.

—**George E Collentine, MD**
Milwaukee, Wisconsin

Editor's note: The brochure was developed by the SMS Commission on Mediation and Peer Review in July 1979 to familiarize patients with the Society's grievance process in receiving, investigating, and resolving differences between physicians and patients. The Commission is chaired by Gerald C Kempthorne, MD, Spring Green. SMS staff directly involved were Doug Nelson and John LaBissoniere of the Health Services Division and Diane Upton, communications coordinator.

The Commission urges physicians who have not already done so to order a supply for display and distribution in their offices. To date, more than 15,000 copies of the brochure have been distributed to patients through physicians' offices.

The Editors would like to encourage physicians to contribute to the LETTERS TO THE EDITOR section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

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In Perspective

BRIAN JENSEN, Director
Physicians Alliance Division

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

Parents, minors, and health care delivery

THE WISCONSIN Legislature is currently considering Senate Bill 188, which would allow health care professionals to provide medical services to consenting minors if the health care professional believes the minor understands the nature and consequences of the service. This bill would, in essence, allow physicians to treat a minor for nonemergency medical problems without informing that minor's parent or guardian. The basis for this expansive bill flows from the already enacted legislation on the national level regarding abortion, and on the state level regarding venereal disease. The above two statutes allow a minor to receive these specific diagnostic and treatment methods without the parent being informed of the service.

A minor is defined legally as someone under the age of eighteen. A minor before the age of 18 may be emancipated by entering into marriage, joining the armed forces, or developing an independent financial support system through employment with or without that minor's parental approval. The following remarks will not be directed to minors in the above emancipated categories.

Senate Bill 188 on the surface seems admirable. However, it does appear to be part of a legalistic trend to emancipate minors before they truly have developed a sense of values by which they will be responsible members of our society. Preadolescence and adolescence occur at different ages for different minors. No truly objective means have been developed to quantitate exactly when this takes place. Nature, however, in its intrinsic wisdom, has developed a slowly evolving process of biologic growth which manifests itself with growing mental, physical, sexual, and emotional capacities. These individual capacities do not develop at the same time, and never develop in some adults.

The legislative system, it appears, desires to somehow or another reshape the biologic time clock. In these efforts the waters become very murky. It appears Senate Bill 188 has fallen into these murky waters. In an attempt to appease the adolescent minor and to harken to the cries of the movement for individual freedom, the proponents of this bill are negligent in their lack of recognition of the right of the family to be involved in the welfare of one of its own members. This family unit has responded in the great majority of situations with concern by the parent for the child with biologic authoritative love and concern.

The family unit nurtures children to adolescence, and stands ready to help them go through this rather stormy time in life, on their way to a hoped-for mature adulthood.

The present emphasis on wellness, as well as the resurgence of the concept of delivery of medical care through family physicians (encompassing internal medicine, pediatric, and family practitioners) is an attempt to strengthen the family's involvement in the health and welfare of its individual members. The parents, by procreating the child, have assumed the primary responsible role of raising the child until that child can be a reasonably responsible individual. Society has requested and expects that these parents, as part of their role, provide love, sustenance, shelter, and educational, moral, and financial support during the days until the age of majority. To remove the parents from the minor's life by the choice of the minor, when that minor is in need of medical care, seems improper and illogical. It is at times of fear that the minor needs either the parent or some other concerned member of the family who can console and advise him or her. As all of us have experienced, a visit for health care engenders a little fear and the minor is not immune to this fear.

EDITOR'S NOTE: 1979 Senate Bill 188, authored by State Senator Fred Risser (D-Madison) is currently pending in the Senate Human Services Committee. The Governmental Affairs Commission of the State Medical Society voted on Oct 10, 1979 to oppose this legislation for some of the reasons cited by Doctor Mehr. The SMS House of Delegates previously voted to support minor's consent legislation *only* for the treatment of venereal disease.—BHJ

Therefore, let us as physicians not turn away from our responsibility to the family unit. We should form a coalition with parents to sustain the primacy of parents' involvement in the delivery of health care to unemancipated minor children, and through this coalition work to defeat Senate Bill 188. It would be a giant step forward in shoring up the already difficult job faced by beleaguered parents in this enlightened society. A carte blanche permission to treat minors without parental involvement appears anarchistic and disruptive.

—Michael P Mehr, MD
Marshfield, Wisconsin ■

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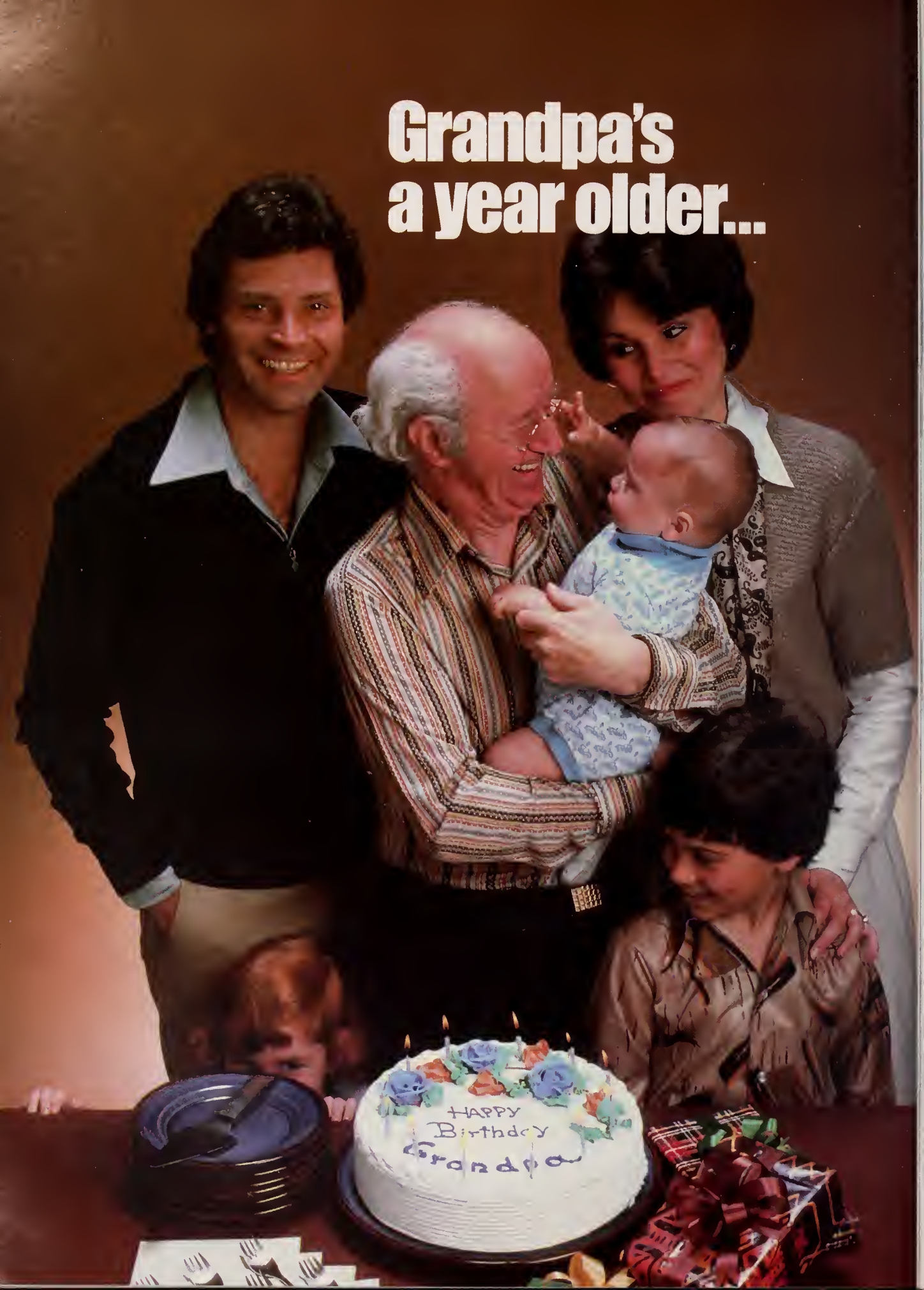

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CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: *PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).*

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Nomenclature	Pneumococcal Types													
U.S.	1	2	3	4	6	8	9	12	14	19	23	25	51	56
Danish	1	2	3	4	6A	8	9N	12F	14	19F	23F	25	7F	18C

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported.

Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe
Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials
For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Staging of Hodgkin's disease

In the past 40 years Hodgkin's disease has been transformed from an inevitably fatal illness to one in which the majority of patients can be cured, even those with advanced disease. This makes it imperative that patients receive proper therapy. Optimal treatment—radiation, chemotherapy, or both—depends upon the stage of disease.

The purpose of staging is to determine extent of disease and to localize tumor volume so that radiotherapists can properly shape treatment fields. Clinical studies in the last 15 years have provided information concerning the natural history of this malignancy. Hodgkin's disease generally spreads through the body in an orderly fashion. This allows us to determine the extent of disease by following an orderly sequence of studies so that patient morbidity is minimized.

Using the current staging classification, stages IA, IIA, and IIIA are usually treated with radiotherapy; stages IB, IIB, and IIIB both radiotherapy and chemotherapy; and stages IVA or IVB chemotherapy alone. New drug regimens now permit patients with early-stage disease, who relapse after initial treatment, to be saved with combination chemotherapy.

Hodgkin's disease usually presents as painless lymphadenopathy. Biopsy of the most obviously involved node should be performed. Cervical and supraclavicular nodes are preferred over inguinal and axillary nodes, because difficulty may arise in distinguishing neoplasia from reactive lymphadenitis. If there is any question regarding pathologic diagnosis, an experienced hematopathologist should be consulted. The morbidity and cost of staging and the treatment require that a definite diagnosis be obtained on the initial biopsy if possible.

Staging begins with a review of the patient's medical history. Symptoms of weight loss, fever, and night sweats indicate advanced or aggressive disease, placing the patient in the "B" category regardless of tumor geography.

During the physical examination all enlarged nodes should be mapped and measured. These nodes are assumed to be involved with Hodgkin's disease. Occasionally, isolated moderate-sized nodes might be biopsied if the presence of disease would alter treatment plans. Liver size and presence of a palpable spleen should be noted.

Laboratory tests done to determine bone marrow, liver, and renal functions and detect complications such as a hemolytic anemia or a paraproteinemia are: complete blood cell count, differential, platelet count, reticulocyte count, Coombs test, sedimentation rate, urinalysis, chemistry panel, creatinine, and protein electrophoresis.

Mediastinal involvement is common in Hodgkin's disease and may be the initial site of adenopathy. Posteroanterior and lateral chest x-ray films evaluate this region best. Lung involvement without enlarged mediastinal nodes is rare, so whole lung tomograms are not routinely ordered. Occasionally, equivocal findings on a routine chest film or bulky mediastinal and hilar nodes need to be evaluated with tomograms. The role of the thoracic computerized tomographic (CT) scan in defining extent of disease in the

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

chest is not clear. It is obtained only if other x-ray films are inconclusive.

Abdominal lymph nodes are involved in one third to one half of Hodgkin's disease patients. Lymphangiograms are an excellent way to assess inguinal, iliac, and lower paraaortic nodes. This test has few false negatives and effectively rules out the presence of disease. Its rate of false positives is low, but pathologic confirmation of suspicious nodes is still wise. Since lymphangiographic dye persists in abdominal nodes for over a year, it offers a means of measuring the effect of therapy on these nodes.

Upper abdominal nodes near the liver and spleen and mesenteric nodes are not evaluable by lymphangiograms. The upper paraaortic nodes are inconsistently opacified. These areas can be visualized by abdominal CT scans, but the sensitivity and reliability of this test is not yet clear; therefore, a laparotomy is required to confirm the presence or absence of disease.

A laparotomy is not needed if evidence of extranodal Hodgkin's disease is found in the bone marrow or liver, thus making the patient stage IV. In this case abdominal node involvement would not change therapy plans, and a laparotomy is unnecessary.

Bilateral iliac crest biopsies are done to investigate the marrow. Aspirates and clot specimens are not adequate.

The liver is more difficult to evaluate. Correlation between liver function tests, liver-spleen scans, and positive liver biopsies is poor. If Hodgkin's disease is clinically suspected in the liver, laparoscopic-directed needle biopsy can prove the presence of disease. A negative biopsy does not preclude the need for laparotomy and liver wedge biopsy.

If bone marrow and liver needle biopsies (if done) are negative, laparotomy should be performed (unless contraindicated) to confirm lower abdominal node involvement suspected by lymphangiograms and to evaluate liver, spleen, and upper abdominal nodes. During a laparotomy, liver biopsies and splenectomy should be done first. If either is positive, prolonged effort to find suspicious abdominal nodes can be avoided.

In selected patients additional tests, such as a bone scan, may be useful. When high cervical nodes or preauricular nodes are present, Waldeyer's ring should be examined and suspicious areas biopsied.

Summary. The extent of disease can be detected by proceeding in an orderly way from a group of simple tests to those with more morbidity, saving laparotomy for last. A particular test is worthwhile only if its results will affect treatment plans or allow monitoring of response to therapy. Tests should not be ordered indiscriminately.

An essential feature of good management is close cooperation between the hematologist-oncologist, radiotherapist, radiologist, and surgeon. Efficient and accurate staging requires the expertise of all these specialists working in concert. The payoff is an excellent chance of cure for a properly staged and treated Hodgkin's disease patient.

—Edward Prendergast, MD
—Paul P Carbone, MD
—Dorothy J Buchanan-Davidson, PhD
Wisconsin Clinical Cancer Center ■

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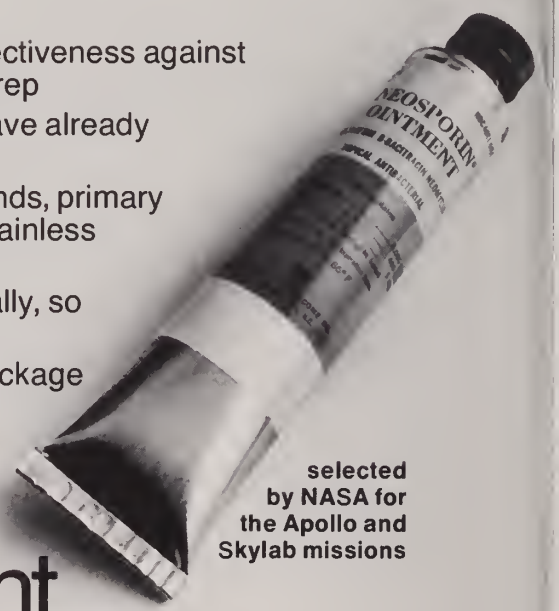

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Scientific Medicine

REFER TO: Meyer GA Introduction to the treatment of lumbar disc disorders. *Wisconsin Med J* 78 21 (Dec) 1979

KEY WORDS: Lumbar disc disorders, lumbosacral radiculopathy, low back pain, computerized tomography, spinal cord tumors

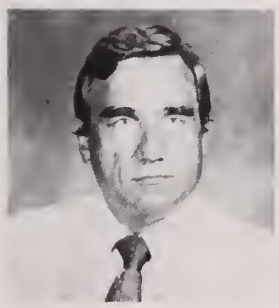
NUMBER 1 OF A SERIES

Introduction to the treatment of lumbar disc disorders

Glenn A Meyer, MD, Milwaukee, Wisconsin

MY COAUTHORS and I would like to introduce to the readers a series of nine brief articles summarizing our current treatment of lumbar disc disorders. Because of the prominent role played by facet joint arthritis, congenital spinal stenosis, and spondylolisthesis in the etiology of lumbosacral radiculopathy, several of the articles deal with these disorders of the vertebral column as related to disc disease. The articles will not discuss less common disorders such as myelodysplasia, spinal cord tumors, infection, and the like while recognizing that these less common problems are often included in an individual differential diagnosis.

The articles are written by specialists in physiatry, radiology, anesthesiology, neurosurgery, and orthopedics. The emphasis is on recent advances and in some instances changes that will likely occur in the next several years. We believe that the subject is timely and important because of the continuing difficulties of conventional medicine in achieving a consistently high success rate with lumbar spine problems. Surgical failures have achieved an identity of their own as "the failed back syndrome." In 1970, the last year for which detailed statistics are available, these patients constituted the fifth largest group of disabled males ages 30 through 50 under the Social Security Disability Insurance Program. The so-called "failed back" patients constitute a majority of the clientele of many pain clinics and oftentimes have disappointing outcomes.



SERIES COORDINATOR
Glenn A Meyer, MD
Associate Professor
Dept of Neurosurgery
The Medical College of Wisconsin
Milwaukee, Wisconsin

The inadequacy of medical knowledge of low back disorders is documented by the extreme variability of approaches to the same patients by different disciplines. Emotionally charged controversies are found in the recent medical literature; for example, the appropriate role (if any) of chemonucleolysis, spine fusion, spinal manipulation, and the like.

The authors feel that it is possible to have a better success rate, and the series of articles includes a number of suggestions that may be of help. The authors are not always in total agreement about points raised in the articles, but we agree that this relatively mundane and unglamorous medical problem deserves more attention and collaborative effort from medical scientists.

We have been encouraged that the application of high resolution computerized tomographic (CT) scanning to the lumbar spine offers exciting new prospects. With further clinical experience and some minor technical refinements, it likely will be possible to complete the radiological evaluation of many cases without myelography. This should diminish patient expense, discomfort, and incidence of postoperative arachnoiditis. The enhanced diagnostic accuracy should improve results with all forms of therapy, both surgical and nonsurgical.

We have enjoyed preparing this series of articles and hope that it will be of use to the readership. ■

REFER TO: Melvin JL, Vasudevan SV: Conservative management of low back pain; a physiatric viewpoint. *Wisconsin Med J* 78:22-24 (Dec) 1979

KEY WORDS: Low back pain, lumbar spine

NUMBER 2 OF A SERIES

Conservative management of low back pain—a physiatric viewpoint

John L Melvin, MD and **Sridhar V Vasudevan, MD,** Milwaukee, Wisconsin

PATIENTS presenting with symptoms of low back pain are commonly seen by physicians. Diagnostic evaluations reveal that most have mechanical disruption of supporting connective tissues rather than significant neural compromise. These respond well to conservative management.[1,2] Such programs promote healing of injured tissues, restore function to weakened muscles, and prevent recurrences by patient education. Treatments to achieve these goals supplement those for the symptomatic treatment of pain as outlined by this paper (Table 1).

Promotion of healing: Immediately following the onset of low back pain, treatment is designed to maximize the restitution of connective tissue integrity and relief of pain. This is accomplished through rest, often virtually total bed rest. Bed rest produces its therapeutic effect by restricting the patient's activity and decreasing gravitational stresses on the lumbar spine. Bed rest at home may be difficult to accomplish, although acceptable for many patients. In cases where this is not practical, hospitalization is recommended. Bed rest is usually beneficial for the first one to three weeks after the acute onset of low back pain. The supine position or a sidelying position with hips and knees flexed (Fowler's position) is preferred.[2] Pelvic traction is used as an adjunct to bed rest. The earlier forms, such as Buck's or Russell's traction, are mechanically inefficient and are not recommended. Traction assists in immobilization and does not cause separation of vertebrae with the weights generally used. Weights of between 5 and 20 lb are used. If it causes discomfort, traction should be discontinued.

Pain relief is provided by use of medications, such as analgesics, antiinflammatory agents and muscle relaxants. Physical modalities in the form of heat and cold are also used for their analgesic effect. Moist heat is generally preferred by patients and provides both analgesia and decrease in associated muscle spasm. This is easily provided with the use of a hydrocollator pack or hydrotherapy (walking tank or Hubbard tank). The choice of heating modality is usually one that the patient can also use at home. Warm tub soaks and heating pads are recommended for home use. Deep heating modalities, such as shortwave diathermy and ultrasound, are also effective in the acute stages of low back pain but are not transferable to a home program.

Restoration of function: After the acute pain is controlled, treatment should prepare the patient for return to increased levels of activity. This is done through strengthening of muscle groups

Table 1—Conservative treatment strategies in low back pain

1. **Relief of pain/inflammation**
   - a. Bed rest
     - 1) Positioning
     - 2) With pelvic traction
   - b. Medications
     - 1) Analgesic agents
     - 2) Antiinflammatory agents
   - c. Modalities
     - 1) Heat
     - 2) Cold
2. **Elimination of painful activities/recurrence**
   - a. Exercises
     - 1) Pelvic tilt
     - 2) Knee-to-chest
     - 3) Partial sit-up
   - b. Postural
     - 1) Back protection in daily activities
     - 2) Ergonomics
   - c. Back supports
     - 1) Corsets
   - d. Other
     - 1) Psychologic support

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supporting the trunk and instructing the patient in techniques to minimize the stresses placed on the lumbosacral spine. In preparation for functional activities, a series of therapeutic exercises are begun. The exercises described by Paul Williams continued to be the mainstay of exercise programs.[3] These exercises are designed to strengthen the abdominal muscles and to stretch the paraspinal muscles and ligaments. The exercises are begun soon after acute pain relief occurs. We emphasize the following three exercises:

A. Pelvic tilt (Fig 1): This exercise is performed in the supine position with hips and knees flexed. The patient presses his lumbar spine firmly against the floor by contracting the gluteal and abdominal muscles, then raising the buttocks off the floor and holds to the count of ten. After this exercise is mastered in the supine position, patients are encouraged to perform this in the erect position.
B. Knee-to-chest (Fig 2): This is also performed in the supine position with the hips and knees flexed. Both knees are clasped with the hands and pulled towards the chest and held to a count of ten.
C. Partial situp exercises (Fig 3): In the supine position, with knees and hips flexed, a partial situp is performed by isometrically contracting the abdominal muscles and holding to the count of ten. These exercises are performed regularly with each exercise done at least ten times, twice daily, indefinitely.

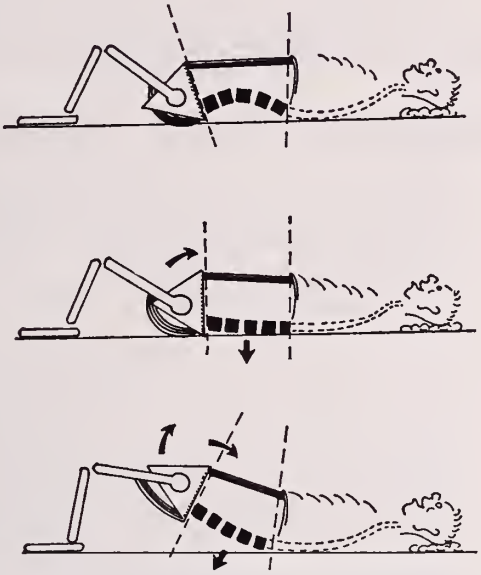

FIGURE 1—The pelvic tilt (reproduced with permission from Low Back Pain Syndrome *by Rene Cailliet, FA Davis Co).*

FIGURE 2—Knee and chest exercise (reproduced with permission from Low Back Pain Syndrome *by Rene Cailliet, FA Davis Co).*

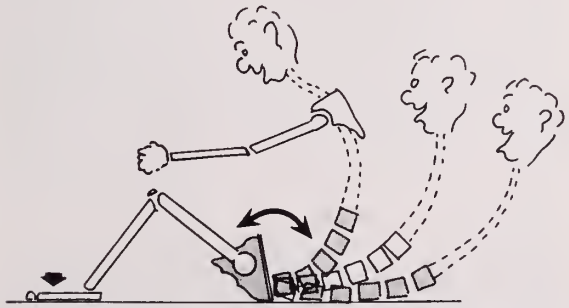

FIGURE 3—Partial sit-up exercise (reproduced with permission from Low Back Pain Syndrome *by Rene Cailliet, FA Davis Co).*

Prevention of recurrence: The emotional and work situation of the patient should receive attention. Patient education and supportive psychologic counseling is needed in the acute stages to decrease associated anxiety. Biomechanical studies of intradiskal pressure by Nachemson indicate that maintenance of proper posture and avoidance of lifting heavy objects in front of the person with the knees straight decreases the intradiskal pressure.[4] Exercise programs should thus be supplemented with posture instructions. The objective is for the patient to use good posture during all future activities, including standing, sitting, and other positions at home and

work. Patients are instructed to avoid excess forward bending as much as possible. When lifting weights, patients should avoid flexion of the lumbosacral spine with the knees straight, but instead should flex the knees and keep the spine straight with the load close to the body. Ergonomics, the application of human and engineering sciences to designing of work and work place, forms an important part of preventing recurrences of back pain. (Example—adjusting the height of work bench).

Lumbosacral corsets are used to remind the patient to avoid extremes of motion. Corsets provide abdominal compression and this increased abdominal pressure decreases the load on the lumbar intervertebral disks. They are more acceptable cosmetically than rigid braces. Use of corsets help in permitting early ambulation.

Summary: Low back pain is a symptom and not a disease. The cause in a majority of cases is mechanical and these respond well to conservative treatment. The rationale of treatment strategies is presented. Abdominal strengthening exercises, postural instructions, and instructions in proper body mechanics constitute the essential strategies for preventing recurrent episodes of low back pain.

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Abstracts

Effective surgical therapy of esophagitis

LELAN F SILLIN, MD; ROBERT E CONDON, MD; STUART D WILSON, MD; LEONARD W WORMAN, MD, Medical College of Wisconsin and Wood Veterans Administration Center, Milwaukee, Wis: *Arch Surg* 114:536-541 (Apr) 1979

During the years 1971 to 1976, 252 patients needed surgical treatment of primary or secondary esophagitis. Major opertions performed were 73 Belsey Mark IV repairs, 55 Hill repairs, and 129 Nissen repairs. In the group with primary reflux, barium swallow tests and endoscopy were useful in confirming the diagnosis in patients with typical symptoms; routine biopsy, lower esophageal sphincter, manometry or an acid infusion test did not add to diagnostic certitude. If symptoms were atypical, a biopsy was helpful but manometry and acid infusion were not. Mean symptom scores in this group of patients were improved by each of the "valve-building" operations. Intraoperative dilation after mobilization of the esophagus coupled with a valve-building operation was successful in managing 26 of 29 strictures. Reoperation after an operation failed carried appreciable morbidity and mortality but resulted in good control of symptoms. Addition of a Belsey or Nissen procedure to myotomy for management of primary esophageal motility disorders diminished symptoms and did not cause disabling obstruction. (Read before the 86th annual meeting of the Western Surgical Association, Scottsdale, Ariz, Nov 15, 1978.) ■

White clot syndrome

JONATHAN B TOWNE, MD; VICTOR M BERNHARD, MD; CLARA HUSSEY, MD; JOHN C GARANCIS, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 114:372-377 (Apr) 1979

Heparin sodium-induced thrombosis is insidious and difficult to diagnose. If untreated, it results in death or major amputation. We have treated seven patients with thromboses resulting from platelet aggregation induced by heparin. Four patients had acute arterial ischemia of the lower extremity, venous gangrene developed in two, and one patient had an occluded autogenous vein femoral popliteal bypass in the immediate postoperative period. The platelet count was noticeably reduced in affected patients. White platelet thrombi were noted in four patients, three of whom had acute arterial occlusion. A white thrombus was the cause of immediate failure of a femoral popliteal graft. Electron microscopic examination of these thrombi demonstrated predominantly fibrin platelet aggregates with an occasional entrapped WBC and a rare RBC. All patients receiving heparin therapy must have platelet counts performed regularly. If thrombocytopenia is detected, platelet aggregation studies are indicated. When abnormal platelet aggregation is noted, heparin therapy should be reversed with protamine sulfate and the patient treated with low-molecular-weight dextran and warfarin sodium. (Read before the 86th annual meeting of the Western Surgical Association, Scottsdale, Ariz, Nov 15, 1978.) ■

REFER TO: Melvin JL, Vasudevan SV, Meyer GA: Electrodiagnostic techniques in evaluation of low back pain. *Wisconsin Med J* 78:25-26 (Dec) 1979

KEY WORDS: Low back pain, neuromuscular diseases, lumbar radiculopathy

NUMBER 3 OF A SERIES

Electrodiagnostic techniques in evaluation of low back pain

John L Melvin, MD; Sridhar V Vasudevan, MD; and **Glenn A Meyer, MD,** Milwaukee, Wisconsin

ELECTRODIAGNOSTIC studies have evolved into a useful addition to the clinical examination in the assessment of neuromuscular diseases. This paper reviews the principles which explain how nerve conduction and needle electromyographic studies contribute to the evaluation of patients with low back pain suspected to be secondary to lumbosacral radiculopathy.

Electromyography is the detection and recording of electrical activity from the neuromuscular system. Clinical electrodiagnostic studies include measurement of conduction velocity of peripheral motor and sensory nerves (NCV), as well as study of muscles by means of needle electrodes (EMG). While in EMG the recorded potentials are either spontaneous or volitional from the muscle, in NCV the potentials detected from muscles or nerves are evoked by electrical stimulation of the nerves. The apparatus used in performing these studies is the electromyograph and the record obtained is the electromyogram.

The clinical electromyographic study provides information regarding the status of the motor unit, the functional unit of the neuromuscular system (Fig 1). This includes the anterior horn cell in the spinal cord, its peripheral myelinated axon, the neuromuscular junction and skeletal muscle fibers innervated by that neuron.[1] The electrical activity of individual motor units, the motor unit action potential, is recorded by inserting needle electrodes into the muscles to be examined. This activity is amplified, displayed on the oscilloscope screen, and simultaneously transmitted over the audio-system of the electromyograph.[1,2]

During normal needle electromyography, the resting muscle demonstrates electrical silence after a needle electrode penetrates it. When the muscle membrane is unstable, as it might be when the axon to it has undergone change, there appear fibrillation potentials or positive sharp waves which are spontaneous discharges of a single muscle fiber. Motor unit action potentials are the summated electrical activity of all the fibers of an individual motor unit. They may be described as polyphasic when the potential includes five or more phases. A neuropathic process may increase the proportion of such potentials.[2]

Nerve conduction velocity measurements involve stimulating a nerve at one point and recording the response either at the muscle or at some distance along the nerve. Electric current

FIGURE 1—The motor unit electrodiagnostic testing helps in differentiating radiculopathy from peripheral nerve root compression.

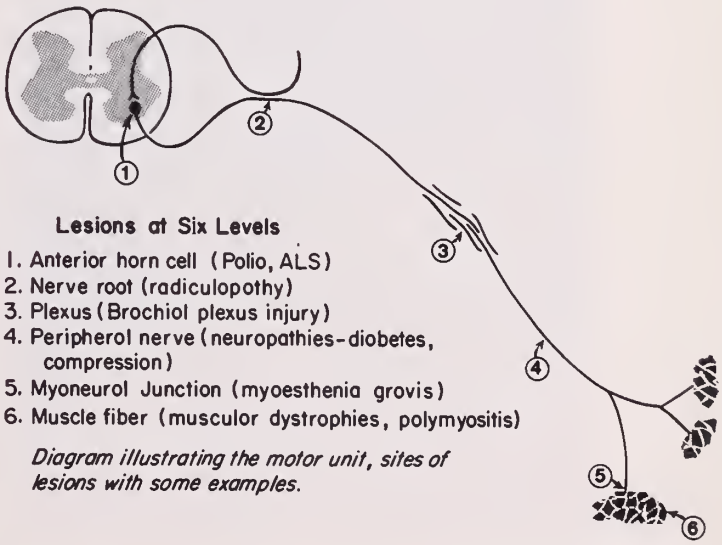

Diagram illustrating the motor unit, sites of lesions with some examples.

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passed through the skin and stimulating the peripheral nerve produces an evoked contraction. When recorded by surface electrodes placed over the muscle, this is called the M response.[1] By stimulating a peripheral nerve at two different points along the course of the nerve and determining the interval from stimulus to response in each case, the nerve conduction velocity is calculated. This velocity is dependent on a variety of physiological factors including age, temperature, and the specific nerve being studied.

Electrodiagnostic tests help to delineate the portion of the motor unit involved by disease. Through determining the pattern of abnormality, they can identify nerve root compression or peripheral nerve involvement. They help in objectively assessing the presence and the level of nerve root irritation.[1,3] They also provide prognostic information regarding functional recovery from nerve injuries depending on whether the lesion is neuropraxic (physiologic block) or axonal degeneration (Wallerian degeneration). Electrodiagnostic tests can be performed safely on patients with virtually any diagnosis. Although occasionally these tests may be uncomfortable, it is rare for pain to interfere with successful completion of the test in either adults or children.

Both nerve conduction studies and needle electromyography should be performed in patients presenting with clinically suspected lumbar radiculopathy. Either of these may reveal abnormalities when traditional neurologic examination procedures produce findings which are equivocal or even when the examination is normal.

Nerve conduction studies contribute largely by identifying the presence of a generalized polyneuropathy or a localized mononeuropathy which may be contributing to the clinical picture. The most common index of peripheral neuropathy is slowing of nerve conduction velocity in the distal segments of more than one nerve. Segmental compression neuropathy of the peroneal nerve unilaterally can cause a foot drop clinically difficult to distinguish from L5 radiculopathy (Fig 1). Conduction studies show slowing in the fibers through the involved segment. The amplitude of the electrical response elicited by stimulating the common peroneal nerve above the region of the fibular head is significantly reduced as compared to the response noted after stimulating somewhat below the point, reflecting a reduction in the number of conducting fibers in this segment.[2] Needle electromyographic examination in these cases reveals abnormalities in muscles supplied by the peroneal nerve if sufficient axonal change has occurred. In lesions of the lumbar nerve roots presenting as foot drop, the two amplitudes of the common peroneal nerve would be similar. Needle electromyographic examination usually reveals abnormality in the leg muscles as well as paraspinal muscles supplied by the L5 root.

Needle electromyography assists in localizing the level of lumbar disc herniation. The procedure compares favorably with myelography. While the myelogram reflects anatomical and structural change, electromyography reflects altered physiological function. The discovery of abnormalities such as positive sharp waves and fibrillation potentials in the muscles innervated by a given segmental level suggests nerve root compromise. The changes in membrane instability in the extremity muscles are not fully developed until approximately 21 days after onset of acute pathology. However, the paraspinal muscles show abnormalities as early as 7 to 10 days after the onset of acute symptoms. In approximately a third of the patients, the electromyographic abnormality is found only in the paraspinal muscles.[3] This is especially true during the first and second week of acute radiculopathy.

In patients with recurrent radiculopathy after laminectomy, electromyographic findings are difficult to evaluate. However, if the electromyogram indicates a radiculopathy at a different level from that which led to the surgery, it is of diagnostic significance even if this appears only in the paraspinal muscles.[4]

Summary: Electrodiagnostic studies provide important information to the clinical examination of patients who present with low back pain suspected to be from lumbar radiculopathy. This paper describes the essentials of nerve conduction studies and needle electromyography. It describes how these studies can differentiate a lumbar radiculopathy from a generalized polyneuropathy or a localized mononeuropathy. Electrodiagnostic studies should be utilized as an extension of clinical examination for they provide additional useful information in assessing the presence and the level of nerve root involvement.

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KEY WORDS: Lumbar disc disease, computerized tomography, low back pain, herniated discs, Pantopaque®, metrizamide, epidural venography, myelography

NUMBER 4 OF A SERIES

Radiologic evaluation of lumbar disc disease

Glenn A Meyer, MD and **Victor M Haughton, MD,** Milwaukee, Wisconsin

THE ESSENTIAL radiographic examinations for diagnosis of a herniated lumbar disc are spine x-rays, myelography, and occasionally epidural venography. Very recently high resolution computerized tomographic (CT) scanning is being used in several medical centers including our own.

Although most plain film radiographic signs are not specific, the plain film examination is helpful in evaluating patients with low back and leg pain. Loss of height of a vertebral interspace suggests disc herniation. Pars interarticularis defects, abnormal configuration of the spinal canal and neoplastic destruction of the vertebral column should be identified prior to performing more definitive radiographic studies of herniated discs.

Pantopaque®, an iodinated "oil" (in reality a fatty acid), has been the most popular myelographic contrast agent in the United States. With Pantopaque®, the diagnosis of a herniated lumbar disc can be highly accurate. The signs of a herniated disc on Pantopaque® myelography are distortion of an axillary pouch or constriction of the arachnoidal sac. Although complications of Pantopaque® myelography are not frequently reported, there is a significant risk of arachnoiditis if any Pantopaque® remains after the myelogram; in addition intravasation of contrast media with pulmonary embolization and idiosyncratic reactions with conus medullaris syndrome, meningismus, hydrocephalus, and death have occurred.

Gas myelography although less frequently used for the diagnosis of herniated lumbar disc was the authors' method of choice until metrizamide (Amipaque®) became available. When performed by an experienced team, gas myelography is essentially without complications. In the lumbar region the diagnosis of a herniated disc may be made by gas myelography when the anterior subarachnoid space is encroached upon at the level of an intervertebral disc (Fig 1). Since the axillary pouches are not well visualized during gas myelography, the diagnosis of a laterally herniated disc is not efficient; however, other causes for the disc syndrome especially intraspinal tumors are effectively ruled out. In the high lumbar

FIGURE 1: Gas myelogram demonstrating a herniated L5-S1 disc. The lateral midline tomogram demonstrates displacement of the dura into the gas filled anterior subarachnoid space.

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and thoracic region, however, gas is preferable to positive contrast agents since the entire subarachnoid space is replaced with the gas outlining the spinal cord both anteriorly and posteriorly. The disadvantages of gas are the requirements of an experienced myelography team and complex motion tomography equipment.

Now that water-soluble contrast media such as metrizamide are in common usage in the United States, they will no doubt replace gas or Pantopaque® for lumbar myelography in many institutions.[1] The advantages of metrizamide are that it is soluble in cerebrospinal fluid and that it is physiologically removed from the subarachnoid space. Its solubility permits better definition of the axillary pouches (Fig 2). With attention to patient position, hydration, and appropriate selection of patients, the risk of complication is extremely low.[2] In the thoracic region, metrizamide may be satisfactory but may also require tomography. Gas is still our agent of choice for most studies of the thoracic region.

The authors have found epidural venography is useful for demonstrating laterally placed lumbar disc lesions. A catheter is introduced into the ascending lumbar vein via femoral puncture. Injection of contrast medium results in opacification of the anterior internal vertebral veins. Herniated discs will cause distortion, displacement or obliteration of these veins. The illustration (Fig 3) shows evidence of a herniated disc obliterating the radicular vein that normally connects the anterior internal vertebral veins with the ascending lumbar vein. The anterior internal vertebral veins on the patient's right side are normal. These findings indicated a herniated disc, and surgical exploration confirmed the findings. The only significant risk in performing epidural venography is that of an adverse reaction to intravenous contrast medium. Anaphylaxis, allergic reactions and death are possible but in most cases epidural venography is reported to be safe and effective. The most important indication for epidural venography is a suspected lateral disc at L5-S1. At this level, epidural venography may be more accurate than Pantopaque® myelography. At other levels it is less accurate.[3]

The authors have compared high resolution CT

FIGURE 2: Oblique radiograph from a metrizamide myelogram. Note the excellent filling of the axillary pouches except L4 (arrow), which is compressed by a herniated disc.

FIGURE 3: Epidural venography in a patient with a herniated L5-S1 disc. The radicular vein on the left (arrows) is obliterated by a herniated disc and the anterior internal vertebral veins (arrowheads) are displaced medially.

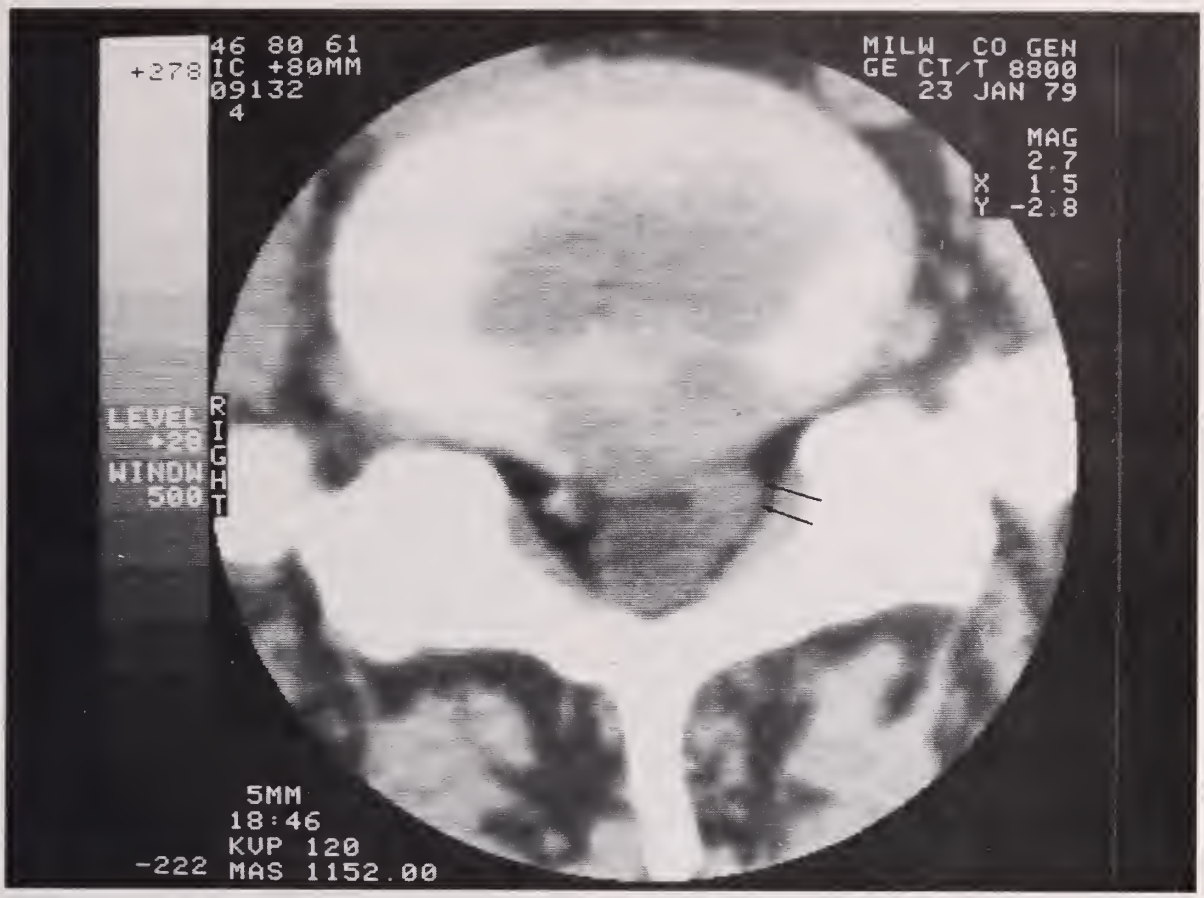

FIGURE 4: Computerized axial tomographic (CT) scan through a herniated L5-S1 disc which protrudes centrally into the anterior epidural fat. A free fragment (arrows) obscures the left S1 root sheath and indents the dural sac. A small droplet of Pantopaque® remains in the nerve root sheath on the right. Epidural fat and the ligamentum flavum are clearly seen.

scanning with Amipaque® myelography.[4] In several recent cases of free disc fragments within the spinal canal, the disc fragment was visualized usually showing its spatial relationship to the involved nerve root. The case shown (Fig 4) and three others were recently confirmed at surgery. Obviously much more experience must be gained at our medical center and others before the role of CT scanning can be assessed. However, the authors are impressed with its potential diagnostic efficiency, especially in the unoperated spine.

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Abstracts

Neonatal cystic choristoma in submandibular salivary gland simulating cystic hygroma

THOMAS T TANG, MD, PHD; MARVIN GLICKLICH, MD; KENNETH A SIEGESMUND, PHD; HERBERT W OECHLER, MD; SAMUEL R McCREADIE, MD, Milwaukee Children's Hospital and the Medical College of Wisconsin, Milwaukee, Wis: *Arch Pathol Lab Med* 103:537-539, 1979

A congenital cystic malformation occurred in the submandibular salivary gland of a neonate. The embryogenesis and differential diagnosis are discussed. Since it seems to be a product of endodermal heterotopic differentiation or entrapment of foregut epithelial rests in the submandibular gland, it is classified as a cystic choristoma. ■

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KEY WORDS: Chronic pain, somatogenic pain, psychogenic pain

NUMBER 5 OF A SERIES

Psychological assessment and treatment of chronic pain patients

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DIFFERENTIATION of somatogenic and psychogenic pain is often difficult, if not impossible. An alternative to making a strict somatogenic-psychogenic distinction, and one which has more direct implications for patient management, is to ask: "Is the patient's pain behavior, from which we are inferring pain, most adequately understood in terms of physical findings, psychological findings, or both." Answers to these questions will enable a comprehensive management of the patient, regardless of the relative contributions of somatogenic and psychogenic processes. What follows is a brief description of psychological mechanisms which may bring about pain, methods to evaluate the contribution of psychological factors to patients' symptomatology, and various psychological treatment strategies for chronic pain.

Psychological mechanisms of pain

Psychogenic pain, *i.e.*, pain which is highly correlated with psychological factors, may occur under a variety of conditions including the following.[1-4]

(1) "Hallucinations of pain" may occur in conjunction with schizophrenia or endogenous depressions, although it is relatively rare.
(2) Pain may be a result of prolonged periods of muscle tension which is presumably secondary to psychological factors (psychophysiological reaction).
(3) Pain may reflect a reactive depression or conversion hysteria, whereby the patient focuses awareness on pain to avoid coping with uncomfortable circumstances.
(4) The complaint of pain may be shaped by its power to bring about medications, surgery, disability compensation, and the like (secondary gain).
(5) For any of the above reasons, patients who have organic lesions may magnify their pain experience.

Regardless of the initial causes for the complaint of pain, whether psychogenic or somatogenic, the more chronic the pain is the more likely the patient's behavior will be influenced by the consequences of the pain in his social relationships and environmental events. If the "pain behavior" yields significant payoffs (*e.g.*, family sympathy and attention, disability compensation, continuation of medication, a doctor's confirmation of invalid status, and the like), the pain is likely to persist and perhaps increase.[1]

Assessment of the chronic pain patient

A. The Interview. Knowledge of the patient's psychological development and the factors precipitating the patient's pain gives interesting insights, but often does not directly indicate treatment guidelines. What is of more interest in the patient's continued care is *why does this patient continue to have pain* (if there are no obvious physical findings), or *why is the patient unable to live with the pain* (if physical findings are present)?[3] Of major interest is discerning the payoff (secondary gain) to the patient which might foster the continuation or magnification of pain. To answer these questions one must present different questions to the patient than those typically included in a mental status examination (which is usually normal in chronic pain patients).

In addition to an assessment of pain characteristics, premorbid social adjustment, and current mental status, it is important to evaluate at least three major areas of the patient's life.

(1) It is important to know the home situation. Does the pain elicit sympathy and attention from family members, facilitate avoidance of less preferred activities (*e.g.*, parental responsibilities,

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household chores, sex, and recreation), or legitimize excessive engagement in more desired activities (*e.g.*, sleeping late, watching TV, and the like)? This information can be obtained by having the patient describe a typical day at home, including interactions between the patient and family members. Often times much of this information can best be obtained from the spouse.

(2) One must inquire about work and financial income. If the patient works, do fellow employees or employer provide sympathy and assume any of the patient's responsibilities? If unemployed, what reasons are given? Few chronic pain patients are totally incapacitated. Almost all are able to work in some capacity if sufficiently motivated. Patients who refuse to seek employment other than their premorbid position strongly suggest psychological overlay. If litigation is pending or disability compensation is occurring, does the patient risk losing such support if he gets better? Because of the financial reward for pain, patients with pending litigation or who are receiving disability compensation are often difficult treatment candidates at best.

(3) It is important to know the history of physician contacts, medical treatments, and medications. Patients who have seen many physicians and have experienced failure with a variety of medical treatments are likely to have strong manipulative tendencies. Patients who have used many medications, with increasing dosages and analgesic potential, are probably abusing medications. The physician should not allow himself to be put in the position of taking complete responsibility for making the patient pain-free. His only job is to diagnose and treat pathology. The complaint of even severe pain by itself, in the absence of organic pathology, is not sufficient to warrant prescription of strong analgesics or surgical intervention.

(4) It is also useful to ask what the patient would do if the pain were gone. This question enables an evaluation of how realistic the patient is in his thinking and self-expectations and aids in the establishment of treatment goals.

Besides being attentive to the content of the patient's answers, useful information can be derived from the manner in which they are delivered, particularly with patients who make repeated medical visits. The physician should be sensitive to manipulative tendencies in whining patients who excessively seek attention and support, demanding complete relief of pain, often praising the physician's reputation or efforts while running through a list of analgesics and other physicians which have been tried and found wanting. Often times, these behaviors are designed to manipulate an increase or change in medication, initiate more drastic procedures, seek a confirmation of the patient's invalid status, or occasionally to simply confound the physician.[3]

The aim of the interview thus, is to identify what the patient might have to give up in terms of payoffs if the pain were not present. Treatment then involves assisting the patient to achieve the desired payoffs with more socially acceptable behaviors rather than pain.

B. Psychological Testing. Objective personality testing is often useful in assessing the degree, nature, and prognosis of existing psychological disturbances. The Minnesota Multiphasic Personality Inventory, an objectively scored true-false questionnaire yielding indices on 10 psychiatric dimensions and three validity indices on attitudinal style, is the most popular assessment instrument. The patient must be at least 16 years of age and have at least 6th grade reading skills to provide valid responses. Generally, such testing does not readily address the psychogenic-somatogenic issue in chronic pain patients, since both groups frequently show similar types and degrees of psychological distress (clinical elevations on indices of hypochondriasis, depression, and hysteria—"the neurotic triad"). However, some authors have found that the relative elevation of these clinical scales offers some prognostic utility.[3] Patients scoring excessively high on measures of hypochondriasis and/or acting out and manipulative tendencies tend to fare poorly in adapting to or recovering from their pain. Conversely, patients who achieve high scores on the scales of depression with or without hysterical tendencies, or score high on measures of hypochondriacal and hysterical tendencies in the absence of depression, tend to have a better prognosis. The most constructive use of such testing is integrating test data with historical and current situational circumstances so that an optimal treatment package can be designed. Such an integration of data is usually best left to professionals trained to interpret the test results.

Treatment strategies

For those patients who show significant levels of psychological distress, manipulative tendencies with family members or physicians, or poor social adjustment, psychological/psychiatric treatment is indicated. However, in order for any treatment procedure to be effective, the patient must want to eliminate or reduce the pain and be willing to work at doing so. It must be made clear to the patient that whatever he gets out of the treatment will be a product of his own doing.

The more successful treatment programs[1,3] usually involve a multidisciplinary treatment in an inpatient setting, with both milieu and group therapy. The orientation generally is one of cop-

ing or "learning to live with the pain," although rarely complete elimination of the pain may be achieved. The treatment centers around a contract between the staff, patient, and family members in which the patient is required to play an active part in achieving successive steps toward realistic goals. Most frequently the goals involve reduction in medications, increase in activity levels, improvement in marital and family relationships, and vocational rehabilitation or adjustment. When the patient has demonstrated meaningful progress as an inpatient, the treatment continues on an outpatient basis. While this inpatient treatment is costly, it may be minimal compared to the cost of repeated physician contacts and medication expense.

There are also several additional treatment procedures which are oriented more to direct symptom abatement.[4,5] Instruction in methods of deep muscle relaxation or relaxation training via biofeedback (particularly electromyographic feedback) may be useful to patients who have a significant anxiety or muscle tension component to their pain. Both procedures have been shown to be helpful in reducing pain or altering pain thresholds, and there is no convincing evidence that one is superior to the other, although some patients might prefer one procedure over the other. The use of hypnosis with posthypnotic suggestions of anesthesia have also been shown effective in reducing pain in both psychogenic and somatogenic patients. A variety of cognitive procedures[5,6] have been used which are aimed at developing habits of attentional diversion away from the pain (*e.g.*, focusing on external events or nonpainful bodily processes, such as breathing, or performing mental computations) or use of fantasy to alter the experience of pain (*e.g.*, imagine an arm is only cold or warm, and the like, and not painful). These procedures may be particularly indicated for patients who are extremely preoccupied with their pain, tend to ruminate about their ailments, or suffer from intermittent bouts of severe pain. While these procedures provide only temporary relief, routine application of the procedures may enable lasting benefits. However, the effectiveness of any of the procedures depends heavily on the motivation of the patient and the intensity of social factors supporting the patient's pain.

In patients having organic lesions, tricyclic antidepressants (*eg*, amitriptyline hydrochloride [Elavil®], amitriptyline hydrochloride and perphenazine [Triavil®]) used alone or in combination with phenothiazines often have a pain reducing effect. Even in low doses, tricyclics may make pain more tolerable, enabling reduction of need for analgesics and perhaps better response to psychological procedures. Antidepressants should not be used in place of psychological procedures, but rather in conjunction with them.

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Abstracts

Prognostic value of pretreatment bone scans in breast carcinoma

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Am J Roentgenol 132:877-881 (June) 1979

One hundred consecutive patients who had ^{99}mTc pyrophosphate bone scans prior to treatment for cancer of the breast between 1972 and 1976 were studied retrospectively to determine the contribution of the scans to staging, treatment, and prognosis. Patients were staged by the AJC-UICC 1973 TNM system using all information exclusive of that from bone scans. Bone scans were initially categorized as normal (60) and abnormal (40). The bone scans were reviewed without knowledge of the initial report; the consistency between the original and review interpretations was 78%. No correlation was found between abnormal bone scans and clinical status of the axillary nodes, but bone scans were significantly more often abnormal in locally advanced tumor (T3 and T4) and in the presence of distant metastasis (M1) (by studies other than bone scan) than in their absence.

The patients were followed during an average period of 22 months. In clinical stages 1 and 11, abnormal bone scans did predict a higher occurrence of distant metastasis (6 of 17, 35%) than normal ones (11 of 48, 24%) and predicted more frequent skeletal metastases: 5 of 27 (19%) *vs* 6 of 65 (9%). A poor 4-year actuarial survival was found in abnormal bone scans (48%) compared with normal ones (58%) among the patients with clinically undisseminated breast carcinoma (stage 1-111). Reader variations and subjective aspects of interpretation clearly can influence the evaluation of bone scans as a clinical tool. ■

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KEY WORDS: Lumbar disc disease, low back pain, sciatica, neurological deficit

NUMBER 6 OF A SERIES

Neurosurgical treatment of lumbar disc disease

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NEUROSURGEONS frequently see a highly selected group of patients referred by other medical specialists. However, unless there is a close and continuing working relationship between the neurosurgeon and the referring specialist, a complete reevaluation of each case must be made by the neurosurgeon. Sophisticated electrodiagnostic and neuroradiologic techniques are applied in almost every case and are necessary to avoid unhappy errors in diagnosis. It is the author's opinion that there is little or no justification for so-called "exploratory" disc operations. It is impossible to visually inspect the surface of the disc without leaving behind perineural scar tissue and relative fixation of the nerve root.

History. The progression from midline low back pain to posterolateral leg pain is almost invariable.[1] In rare instances there is an isolated episode of trauma with rupture of the annulus fibrosis and herniation of the nucleus pulposus. This rarely occurs after the age of 30.

An assessment of the patient's psychological state, particularly secondary gain factors, is absolutely essential when intractable pain is the indication for surgery. If the neurosurgeon lacks the time or inclination to make such evaluations, the help of colleagues in clinical psychology or psychiatry should be obtained.

Mechanical signs of lumbar disc disease. The patient must be disrobed and observed carefully while walking and going through a range of motion of the lumbar spine. Particularly reliable signs include rotatory scoliosis of the spine caused by unilateral lumbosacral muscle spasm when flexion is attempted. Other reliable signs are the seated and recumbent straight leg raising sign which must elicit pain along the course of the sciatic nerve. Even more reliable is the so-called crossed-reference straight-leg raising sign or Fajersztajn's sign.[2] Spinous process tenderness to palpation and sciatic nerve tenderness at the sciatic notch are helpful confirmatory findings.

Neurologic examination. This includes evaluation of flexor and extensor groups of the calves by having the patient walk on heels and toes, and inspection of all the major muscle groups of the leg while observing for atrophy and fasiculations. Pinprick is the most reliable single sensory examination with emphasis on the L4 through S1 dermatomes in the foot, but also with a screening examination of the remainder of the lumbar, sacral, and thoracic dermatomes. Diminution of knee and/or ankle deep tendon reflexes is usually a reliable indicator of nerve root impairment, but requires correlation with other neurological findings.

Acute midline disc ruptures are unusual, but they represent a true medical emergency when accompanied by major neurologic deficit. They usually are manifested by bilateral signs and symptoms of nerve root compression and/or sphincter dysfunction. Such lesions may partially collapse the low lumbar subarachnoid space rendering spinal puncture for myelography difficult or impossible at the involved level.

Rarely, a stoic patient may have a "painless" foot drop caused by a ruptured lumbar disc. After ruling out peripheral neuropathy with electrodiagnostic studies, such patients may be helped by disc excision; however, motor recovery usually requires many months.

Operative considerations. The following comments are intended to give an impression of a few of the essential aspects of lumbar disc operations for the nonsurgeon.

As with any elective surgical approach to deep structures of the body, preoperative skin preparation is mandatory. Twice daily scrubbing with bacteriocidal soap should be done for several days prior to surgery. The three standard operative positions are prone on chest rolls, the kneeling or modified knee-chest position, and the lateral decubitus position. The essential feature is avoidance of compression of the anterior abdominal

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wall with resultant increased venous pressure transmitted to the epidural veins and causing difficulty with hemostasis. In the obese patient, the lateral decubitus position may be the only way to accomplish this.

In the young patient with a relatively normal spine, a very limited or a laminotomy approach is used to minimize epidural scarring.[3] At the L5,S1 interspace disc excision can occasionally be accomplished by removing the ligamentum flavum only. The operative approach is narrow and deep and in many operating rooms a head light and loupe or microscope may be the only way to accomplish adequate lighting and visualization.[4] The use of a bipolar coagulation unit is essential to control epidural veins without heat damage to the nerve roots.

In the older patient with osteoarthritic spurs encroaching on the neural foramina, performing a foraminotomy may be essential. The spurring may either encroach anteriorly, from the vertebral bodies, or posteriorly, from the fascet joints. Doing an adequate foraminotomy usually requires removing the medial aspect of the facet joint, but almost invariably the lateral aspect can be spared, thus leaving intact a worthwhile stabilizing force for the interspace. In the older patient spinal stenosis commonly coexists with the disc, and if so, a complete laminectomy of the involved segment is indicated.[5]

The disc excision requires evacuating all nuclear and most of the annulus material from the interspace. The cartilaginous end-plates ordinarily are not involved in the disc rupture and if not involved, should be left intact. In removing the disc material, extreme care is taken to not penetrate the abdominal cavity risking damage to major vascular structures or the ureter.

The postoperative care is directed toward prevention of bladder distention, monitoring for possible blood loss, and early ambulation, usually the evening of surgery, to prevent thromboembolic disease. Anticoagulants are used only when absolutely necessary in the first few postoperative days because of the risk of intraspinal hemorrhage.

Summary. Almost all patients with an acute herniated lumbar nucleus pulposus complain of sudden onset sciatica. Initially, they are given plain lumbar spine x-rays and are placed at bed rest followed by graded back exercises and training in back protection techniques.

Electrodiagnostic studies, complete spine x-ray films, computerized tomographic (CT) scans, myelography and/or venography, and often cystometrography are utilized as follows:

(a) Immediately, if a mid-line disc rupture is suspected due to bilateral radiculopathy or sphincter impairment,

(b) Near the end of one week of bed rest, if there has been failure to improve from a functionally impairing neurological deficit (*e.g.*, foot drop),

(c) If the patient is still disabled by pain after two weeks bed rest, or

(d) At six months if recurring bouts of sciatica are preventing normal life and it is found that secondary gain is not playing a major role in perpetuating the disability.

With a herniated nucleus pulposus in a relatively normal spine, surgery is focused on the one or rarely two compressed nerve roots with minimal anatomic disruption of surrounding tissues. Many older patients with chronic radiculopathy require complete laminectomy of the involved segments and occasionally foraminotomies.

Congenital anomalies of the spine or spinal cord, spinal stenosis, neoplasia, and infection often must be considered in the differential diagnosis.

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FILM: Correction of a herniated lumbar disc, by Dr Glenn Meyer

Doctor Meyer is author of a surgical-technique film dealing with the correction of a herniated lumbar disc. Prepared at the request of the American College of Surgeons, the film was produced for the Cine Clinic, a joint educational endeavor of the ACS and Davis & Geck, a department of Lederle Laboratories Division, American Cyanamid Company. It is available for screening to medical groups from the ACS Surgical Film Library, maintained at Danbury, Connecticut by Davis & Geck, manufacturer of surgical sutures. Phone: Dorothy A Peterson (914) 735-5000, ext 2493, or New York City Tie Line 562-6526.

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KEY WORDS: Intervertebral disc disease, low back pain, lumbar facet joints, facet block, facet joint disease, facet block technique

NUMBER 7 OF A SERIES

Lumbar facet arthrography and injection in low back pain

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THE LUMBAR facet joints have been established as a source of low back pain which may radiate to the leg. Since the reports by Mixter and Barr[1] in 1934, a great deal of emphasis has been placed on intervertebral disc disease as a dominant cause for low back pain. As early as 1933, however, Ghormley[2] pointed out that the lumbar facet joints are a significant factor in causing low back pain, and he was the first to use the phrase "facet syndrome." Later work by Badgley[3] and a more recent report by Rees[4] have continued to emphasize the role of the lumbar facet joints in low back pain. Mooney and Robertson (in an elegant series of experiments and review of the literature) have presented compelling evidence that the lumbar facet joints can be the origin of low back pain (which can be localized or can radiate down the leg).[5] They have also suggested that stimulation of normal lumbar facet joints can produce some types of electromyographic (EMG) abnormalities, abnormal deep tendon reflexes, and inhibited straight-leg raising.

Using a modification of the facet block technique described by Mooney and Robertson, we have studied a number of patients with chronic low back pain radiating to the buttock or leg.

Technique. During our preliminary investigation of facet block techniques, we chose to inject facet joints with abnormalities evident on radiographic examinations, joints on either side of the abnormal facets, or facet joints at the same level as a radiographically abnormal intervertebral disc.

The facet joints are punctured percutaneously using 1% lidocaine hydrochloride for local anesthesia. Under fluoroscopic control with the patient lying prone, a 22-gauge spinal needle is directed to the expected location of the inferior portion of the facet joint (Fig 1). When the needle tip contacts bone, the patient is placed in an oblique position and the needle tip is directed into the facet joint (Fig 2). Correct position of the needle tip within the facet joint is verified by injecting a small amount of water-soluble radiopaque contrast material (Fig 3).

If a provocative test for back pain is done, we inject 2-3 ml of 5% saline solution into the facet joint and the patient is asked about pain, pattern of radiation, and similarity between the induced pain and previous spontaneous back pain. In the majority of our patients, however, no stimulation is performed and the facet is blocked immediately. Once the needle is in place, the facet joint is injected with 15-20 mg methylprednisolone acetate suspension, followed by 3-5 ml 1% lidocaine hydrochloride solution or an equal mixture of lidocaine solution and bupivacaine hydrochloride (2.5 mg per ml) solution.

After the injection, the needle is withdrawn and the patient observed for 5-15 minutes in the Radiology Department. The patient is then asked to report his impressions about his back pain, and is asked to perform any maneuvers which he knows will induce his symptoms.

Discussion. As summarized by Mooney and Robertson in their studies and review of the literature, stimulation of the facet joints can cause pain indistinguishable from that commonly associated with lumbar disc disease. They report that objective tests such as EMG, deep tendon reflexes, and straight-leg raising may be abnormal in patients with abnormal facet joints, or following facet-joint stimulation.[5]

The mechanism of pain production in facet disease is uncertain. The facet joints are capable of a variety of gliding motions, and their articular surfaces are not in perfect apposition. Richly innervated and vascularized synovial villi have been described between the articulating surfaces.[6] One possible cause of pain is pinching or crushing of these villi, which become hypertrophied in degenerative disease, during movement of the facets.

The innervation of each facet joint arises from the posterior primary ramus at its own level and the level above.[7,8] Anatomic studies have only

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FIGURE 1—Fluoroscopic spot film with the patient supine prior to final adjustment of the needle tip.

FIGURE 2—Fluoroscopic spot film with the patient oblique demonstrates positioning of the needle tip within the lower portion of the facet joint.

revealed innervation of the facet joints from ipsilateral posterior primary rami; no nerve supply crossing the midline to the facet joints has been found. The overlapping segmental nerve supply to the facet joints may help to explain why the distribution of back and leg pain is not specific for a particular facet level. Mooney and Robertson reported that the L4-5 and L5-S1 facet joints are frequently involved in back pain which radiates down the back of the leg, and that the L2-3 and L3-4 facet joints seem to be associated with pain on the side of the leg and in the area of the greater trochanter.[5] Our findings in a smaller group of patients are similar.

The role of the facet block in the evaluation and treatment of patients with low back pain is difficult to define. Since objective criteria for primary facet joint disease are not yet established, most patients have had facet blocks either following extensive diagnostic studies and therapy for disc disease, or because they do not demonstrate objective neurologic findings indicating disc disease. Radiographic examination of the facet joints is difficult and is confusing because many asymptomatic patients have radiographically abnormal facet joints. In an extensive study and review of the world literature, Spangfort found that only 46% to 60% of reported patients treated surgically for presumed lumbar disc disease re-

FIGURE 3—Contrast injection following precise positioning of the needle tip demonstrates the articular surfaces and part of the capsule of the lumbar facet joint.

ceived complete relief of their low back pain and sciatica.[9] Mooney and Robertson found that of 100 patients treated with injections of the facet joints, 62% of patients had complete relief of back pain immediately following injection, and 52% of patients had at least partial, if not complete, relief at six months following facet block.[5] These suggest two considerations. Clearly the lumbar disc is not the exclusive source of chronic low back pain and sciatica. Structural, degenerative, or inflammatory disease of the facet joints may represent a major cause for low back pain with or without sciatic radiation. Facet joint disease may also cause some of the objective abnormalities such as altered deep tendon reflexes and abnormal EMG which are classically associated with lumbar disc disease. Obviously, the objective study of low back pain syndrome is difficult. The return of physical and electromyographic findings to normal is clearcut evidence of therapeutic effectiveness. This does not, however, indicate a specific pathophysiologic mechanism of an individual's pain. At present, a detailed study using standard radiography and high resolution computed tomography is underway to try to establish objective radiographic criteria for facet joint disease. These techniques appear promising and may furnish better criteria for the diagnosis of facet joint disease.

The facet block technique offers a relatively safe and objective way of evaluating (and treating) back pain originating from the lumbar facet joints. Facet joint disease may represent a major cause of chronic low back pain and sciatica, and investigation of the facet joints should be considered in patients with problem chronic low back pain which does not clearly originate in the intervertebral disc.

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Abstracts

Cure of acromegaly by operative removal of an islet cell tumor of the pancreas

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We studied a 30-year-old woman in whom acromegaly was cured by operative removal of a large cystic beta cell adenoma of the pancreas. We detected substantial amounts of immunoreactive human growth hormone (hGH)-like activity in a tumor tissue extract. Extracts of the tumor and a normal human pituitary gland eluted from a Sephadex® G-75 column in two identical peaks. Serial dilutions of the tumor extract displaced radioactive ^{125}I hGH parallel to a standard curve.

Surprisingly, an extract of a normal human pancreas contained large amounts of hGH-like activity and gave results similar to those of the tumor extract on gel chromatography and on serial dilution displacement in the growth hormone immunoassay. Paper electrophoretic studies of ^{125}I hGH after incubation with normal pancreatic and tumor extracts with and without enzyme inhibitors suggested that pancreatic proteolytic enzymes damaged the ^{125}I hGH used in growth hormone radioimmunoassay and produced a false detection of hGH.

Although the evidence is indirect, we postulate that the beta cell adenoma produced a growth hormone-releasing substance that produced acromegaly by stimulating excess secretion of pituitary growth hormone. ■

Optic nerve decompression

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Arch of Ophthal 97:1459-1461 (Aug) 1979

A child had an inoperable arterial venous malformation with chronic papilledema first noted at age eight months. Bilateral optic nerve decompressions were performed with satisfactory results. What appeared to be medulated nerve fibers developed in the retina of one eye five and a half months after surgery. ■

REFER TO: Abram SE: Nerve blocks for low back pain. *Wisconsin Med J* 78:38-39 (Dec) 1979

KEY WORDS: Nerve block, low back pain, lumbar radiculopathy, myofascial pain, sympathetic dystrophy, sacroiliac strain

NUMBER 8 OF A SERIES

Nerve blocks for low back pain

Stephen E Abram, MD, Milwaukee, Wisconsin

NERVE BLOCKS employing local anesthetics and, in certain conditions, long-acting corticosteroids, are effective in treating several low back disorders. Such injections act to diminish reflex-induced muscle spasm and vasospasm, isolate peripheral foci of noxious stimulation, and reduce chronic inflammatory processes. They also may be of diagnostic help in elucidating pain mechanisms and pathways in certain patients. Some common low back problems which are often amenable to injection therapy will be discussed.

Lumbar radiculopathy. Soon after Mixter and Barr[1] demonstrated the relationship between sciatica and rupture of the intervertebral disc, surgical disc removal became the established treatment for radicular pain in the lumbar region. It was assumed that mechanical pressure of the herniated disc on the nerve root was the source of pain and that disc removal should be the proper treatment. It later became apparent that many patients failed to demonstrate mechanical compression of nerve roots either on myelography or at surgery, and a disappointingly high proportion of sciatica patients failed to benefit from surgery despite obvious nerve root pathology. Physicians, therefore, began to seek alternate therapeutic measures.

In the 1950s, injection of long-acting corticosteroids into the epidural space was first reported. Rationale for such treatment was based on histologic evidence of chronic inflammatory and proliferative changes of involved nerve roots. Reported series of epidural and subarachnoid steroid injections since that time indicate that the majority of patients are improved by such treatment and that 40% or more experience complete relief.[2]

Lumbar disc degeneration causes radiculopathy by two distinct mechanisms: (1) nerve root compression and mechanical irritation from disc herniation, and (2) chemical irritation of the nerve root from perineural spread of the contents of the nucleus pulposus (disc material has been shown to produce severe inflammatory responses in laboratory animals). The use of epidural steroids early in this disease before irreversible neural damage would seem logical and may alter the course of the process before irreversible changes occur.

Our evaluation of the sciatica patient consists of a detailed history, including social and psychological as well as physical factors, and a careful physical examination. Patients are selected for epidural steroid injection because of evidence of lumbar radiculopathy (dermatomal pain distribution, pain on straight-leg raising, sciatic notch tenderness, motor, sensory and reflex changes.) Patients with progressive motor or sensory changes are referred for further neurosurgical evaluation. Patients with obvious social, behavioral or psychological components to their pain problems are offered the indicated consultations.

Epidural injections are performed at a segmental level as close as possible to the involved nerve root. The epidural space is identified using a loss of resistance technique. A combination of 1% lidocaine, 5 to 7 ml, and 50 mg triamcinolone diacetate, a "depo" type corticosteroid, are injected. The local anesthetic serves to document spread of medication to the involved root.

Patients are reevaluated at weekly intervals. Those who are unimproved at the end of a week get no further treatment. Patients who are partially relieved after a week receive repeat injections (up to a total of three). Patients who do well for a period of months but have a recurrence of radicular pain are given one repeat injection.

About 55% of our patients improved markedly following epidural steroid injection for at least several months. Careful screening of patients with obvious psychological problems, employment-related injuries, monetary compensation for pain problems, and pending litigation can improve these statistics.

Myofascial pain. The term "myofascial syndrome" refers to a painful disorder or group of disorders characterized by pain of muscular ori-

Doctor Abram is Assistant Professor, Department of Anesthesiology, Medical College of Wisconsin, Milwaukee, Wisconsin. Reprint requests to: Stephen E Abram, MD, Dept of Anesthesiology, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Copyright 1979 by the State Medical Society of Wisconsin.

Table 1. Low back disorders which may be amenable to nerve blocks

Clinical problem	*Pain character*	*Pain distribution*	*Clinical findings*	*Treatment*
Lumbar radiculopathy (sciatica)	Shooting, aching	Follows one dermatome	Pain on straight-leg raising sciatic notch tenderness ± segmental sensory or motor deficit	Epidural steroid injections, one week apart, up to three injections
Myofascial pain	Aching or sharp, shooting	Variable	"Trigger points" pressure causes local and referred pain	Trigger point injection with local anesthetic, every other day, 3 to 5 injections
Sympathetic dystrophy	Burning or aching	Variable, often along vascular distribution zones	Pain on light touch; skin cool, moist; edema, cyanosis	Lumbar sympathetic blocks, every other day, 3 to 5 injections
Sacroiliac strain	Aching	Sacral area, radiating to hips, thighs	Tender over sacroiliac joint; pain with iliac compression	Infiltration sacroiliac joints with steroid and local anesthetic, one week apart up to three injections

gin. The hallmark of the condition is the presence of "trigger points" or discrete areas of tenderness. Pressure applied to these points produces severe pain locally and referred pain in other areas, named reference zones by Travell.[3]

Myofascial pain involving lumbar and gluteal muscles may closely mimic lumbar disc disease. A particularly troublesome diagnostic problem is the piriformis syndrome. Spasm of the piriformis muscle produces irritation and neuralgia of the sciatic nerve, difficult to distinguish from lumbar radiculopathy.

Our treatment of myofascial syndromes consists of a series of local anesthetic injections of trigger points every two to three days. Three to five injections are usually necessary to produce lasting relief. Injections should be followed by exercises to stretch involved muscles while analgesia is present. Transcutaneous electrical stimulation, applied over trigger areas, may be a useful adjunct.

Sympathetic dystrophy. Pain radiating into the leg may be neither radicular nor myofascial in origin. We have encountered several patients with long standing low back problems who have developed causalgic leg pain, usually following rhizotomy or lumbar disc surgery. These patients complain of burning pain and hyperesthesia and may have diminished or labile skin temperature, edema, cyanosis, and hyperhydrosis of the involved extremity.

A diagnostic lumbar sympathetic block will usually reveal the origin of the pain. Pain relief is usually profound following local anesthetic block of the sympathetic chain and outlasts the duration of the anesthetic by hours or days. A series of three to five blocks will usually produce lasting improvement. Occasional patients are temporarily relieved by each block, but fail to get long-term benefit. Surgical sympathectomy may be helpful, but it has a significant recurrence rate despite loss of sympathetic activity.

Sacroiliac strain. Chronic strain of the sacroiliac joints produces mild to moderate aching pain originating in the hips and radiating down the thighs. It may be unilateral or bilateral. Pain is reproduced by pressure directly over the joint or by compression of the iliac crest in the lateral recumbent position. We have seen patients with radicular pain who subsequently developed chronic sacroilitis, perhaps because of an antalgic gait with altered low back mechanics.

We have found infiltration of the posterior sacroiliac ligaments and joints with corticosteroids and local anesthetic to be of diagnostic and therapeutic value. Patients generally are relieved for the duration of the local anesthetic but experience a transient increase in pain for 12 to 24 hours. Pain then gradually subsides over the next day or two.

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REFER TO: Schwab JP, Meyer GA: Lumbar fusion.
Wisconsin Med J 78:40-42 (Dec) 1979

KEY WORDS: Lumbar fusion

NUMBER 9 OF A SERIES

Lumbar fusion

Jeffrey P Schwab, MD and **Glenn A Meyer, MD,**
Milwaukee, Wisconsin

SURGICAL fusion of the lumbar spine plays a role in the treatment of several diseases as seen in Table 1. In the first four conditions, the role of fusion is generally accepted. However, in the more common pain syndromes caused by disc or facet disease, the role of fusion is controversial and less well defined. The problem common to all, except tuberculous infection, is instability. This instability leads to abnormal motion and secondary pain.

Table 1—Indications for lumbar fusion

A. Generally accepted:
1. Tuberculous vertebral osteomyelitis.
2. Scoliosis.
3. Fracture-dislocation of the lumbar spine.
4. Spondylolysis/spondylolisthesis.

B. Controversial:
5. Herniated nucleus pulposus.
6. Degenerative disc disease.
7. Degenerative joint disease of the facets.

1. Anterior fusion is done to halt disease in tuberculous vertebral osteomyelitis.[1] Fortunately, this is rare in the United States today.

2. Scoliosis is a developmental or paralytic instability which, when progressive, is often treated by posterior fusion and instrumentation.

3. Fracture-dislocation with resultant loss of spinal stability and/or neural impairment is at times treated by decompressive laminectomy. Unfortunately, oftentimes this procedure fails to induce neurologic recovery while at the same time increasing the instability. Laminectomy is indicated only in unusual cases such as those with posteriorly in-driven bone fragments or progressive intraspinal hematomas. In most cases fusion is done to obtain stability and may be combined with an anterior decompression.

4. Spondylolysis and spondylolisthesis (Figs 1A and 1B) are forms of posterior spinal instability with anterior slippage of the vertebral bodies. The process is often associated with pain and/or radiculopathy. Although many types of spondylolisthesis occur, the most common is a stress fracture between the articular processes (pars interarticularis). The fracture fails to heal and becomes a fibrous nonunion which then allows the forward slipping.

In the young patient with disabling back pain and spondylolisthesis, spinal fusion is indicated. Some older patients are best managed nonsurgically. If signs and symptoms of radiculopathy coexist, removal of the loose, posterior elements, decompression of the nerve roots and fusion is indicated. The bilateral-lateral fusion is the most common fusion for spondylolisthesis.

The role of fusion in the treatment of herniated nucleus pulposus, disc degeneration and facet disease is controversial and practice varies widely between different specialties and geographic areas.

The clinician's problem is that the exact pain mechanisms often remain obscure. A patient may have x-ray findings of one problem and actually have several others as well. For example, degenerative disc disease may be accompanied by obesity, poor posture, muscle weakness, inactivity, and the like. Thus, merely fusing the spine may not correct the problems. To date, no foolproof method of selecting those patients who will benefit from fusion has been found. The authors are utilizing such techniques as selective nerve root injections, facet injections, psychologic testing, computerized tomography, and the like. These help determine the cause of a patient's pain and allow more rational treatment.

If the patient's clinical picture is one of nerve root involvement with leg pain (sciatica) and appropriate physical findings, then disc excision alone is indicated. The equivocal benefits of fusion coupled with the increase in operative time and morbidity make fusion of dubious value in routine cases of herniated nucleus pulposus. For disc disease with radiculopathy and a large component of back pain or a recurrent radiculopathy at a previously operated level, fusion should be considered.

If fusion is elected as part of the treatment, the surgeon has several techniques to consider. Fusion can be done posteriorly, laterally or anteriorly (Fig 2).[2,3] Posteriorly, the spinous processes, lamina and facets are incorporated in the fusion. Laterally, the lateral facets and transverse processes form a gutter in which to lay the graft. Finally, anteriorly, the discs are excised and graft between vertebral bodies done. Autogenous iliac

From the Department of Orthopedics and Department of Neurosurgery, Medical College of Wisconsin, Milwaukee, Wisconsin. Reprint requests to: Jeffrey P Schwab, MD, Dept of Orthopedics, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Copyright 1979 by the State Medical Society of Wisconsin.

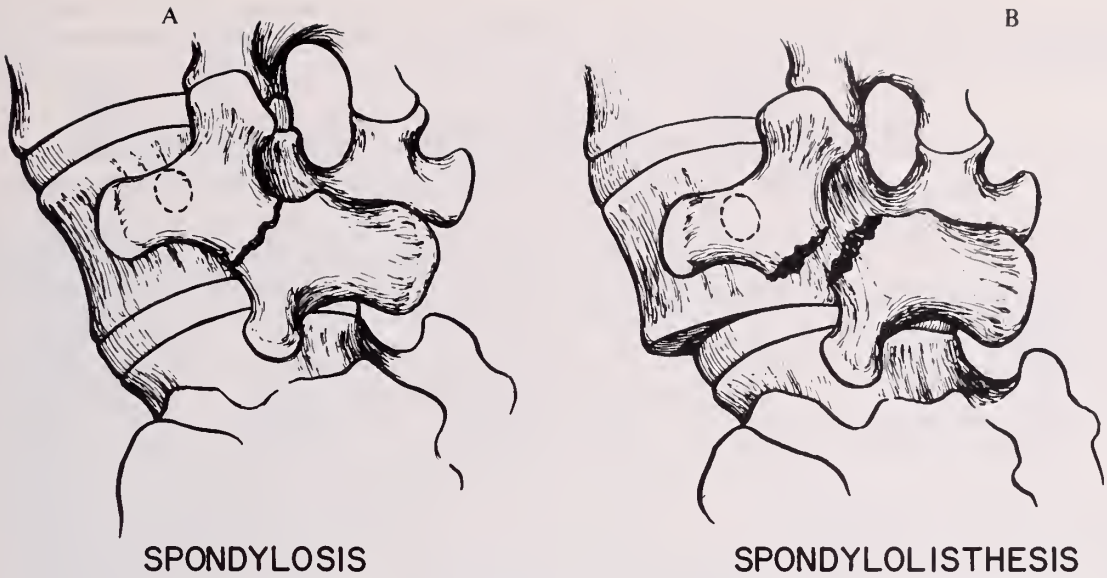

FIGURE 1—(A) Interruption in pars interarticularis without any forward slippage of the cephlad vertebra. (B) Pars interarticularis defect with slippage of the cephlad vertebra.

bone is the best graft material; however, rib is commonly used with anterior fusion and bone bank allograft has been used.

The posterior fusion is used for scoliosis, fracture-dislocations and others. The lamina and facets are decorticated and cancellous bone strips applied. In some instances posterior instrumentation is used in conjunction with the fusion. If one must fuse in the area of a large posterior defect, *eg,* spondylolisthesis, post laminectomy, a lateral or anterior fusion should be considered. Placing the bone directly posteriorly in this case may result in an iatrogenic spinal stenosis from the encroaching fusion mass.

The lateral (bilateral-lateral, intertransverse process, gutter) fusion is another technique. This is done by approaching the spine posteriorly and exposing the spine from facet joint to transverse process. The graft is then laid bilaterally in the lateral troughs one has created. This has the advantage of being close to the flexion-extension axis of the spine and requires minimal immobilization postoperatively. It also has a high fusion rate, particularly in one or two level fusions. It is popular in the surgical treatment of spondylolisthesis.

The anterior transabdominal retroperitoneal approach is a more extensive surgical procedure and associated with a higher nonunion rate than the other techniques. This may be a useful technique for refusion and is also used in the very unstable spine in conjunction with a posterior fusion. The anterior technique is recommended for

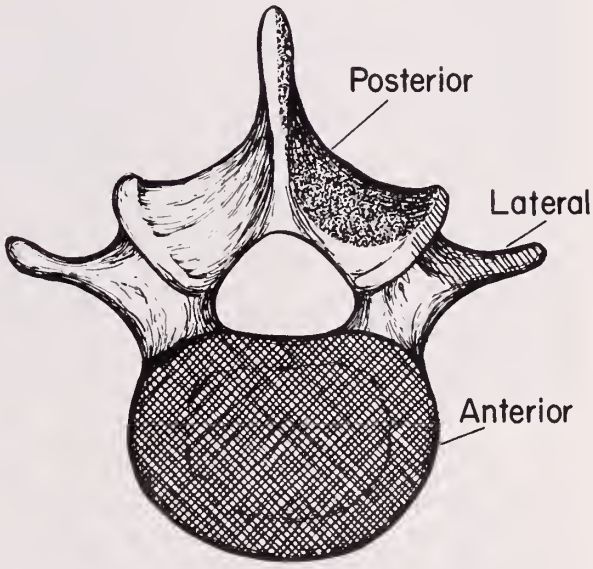

FIGURE 2—Areas utilized in spine fusion.

tuberculous infections of the spine.

Cloward described an intervertebral disc fusion approaching the spine posteriorly, retracting the dural sac, and exposing the interspace. In his hands, this has been a very successful technique and is particularly appealing in secondary disc surgery.[4]

Larson has described a lateral, extracavitary approach to the spine which is most useful in vertebral body diseases or trauma to the spine.[5]

Fusion of the spine is useful in a number of conditions most of which have instability or degeneration as the underlying problem. The indication in tuberculosis, scoliosis, spondylolisthesis and fracture-dislocation is standardized. However, in the low back pain syndromes that

Diagnosis of occult familial medullary carcinoma of the thyroid using Pentagastrin

JAMES R STARLING, MD; CURTIS HARRIS, MD; and DARYL K GRANNER, MD, University of Iowa Medical Center and VA Hospital, Iowa City, Ia: *Arch Surg* 113:241-243 (Mar) 1978

Medullary carcinoma of the thyroid is unique in that it can often be diagnosed solely on the basis of abnormally high basal serum thyrocalcitonin levels. Two brothers described in this report were found to have normal basal serum thyrocalcitonin levels when examined after another family member died from metastatic medullary carcinoma of the thyroid. Pentagastrin, a synthetic analog of gastrin, was subsequently administered to these two high-risk relatives and found to stimulate the release of thyrocalcitonin to abnormally high levels. They were found to have occult medullary carcinoma of the thyroid. Eight other first-degree relatives of the deceased patient with normal basal serum thyrocalcitonin levels were screened with Pentagastrin and found to have normal stimulated levels of thyrocalcitonin. This report reinforces the need to recognize that medullary carcinoma of the thyroid can be familial and that physicians are obligated to screen asymptomatic kin who are at high risk. We recommend that all susceptible relatives, even if they have normal basal serum thyrocalcitonin levels, undergo the provocative Pentagastrin test with repeat annual testing if necessary. In addition, the provocative Pentagastrin test can be used to follow up patients who have undergone thyroidectomy. (Doctor Starling is presently at University of Wisconsin Hospital & Clinics, Madison, Wis) ■

Response to corticosteroids in the hypereosinophilic syndrome

ROBERT K BUSH, MD; MARIO GELLER, MD; WILLIAM W BUSSE, MD; DK FLAHERTY, MD; and HELEN A DICKIE, MD, Madison, Wis: *Arch Intern Med* 138:1244-1246 (Aug) 1978

The hypereosinophilic syndrome is a state of marked eosinophilia (greater than 1500/cu mm) of unknown cause which is accompanied by multiple organ system dysfunction. Initial studies reported a high degree of mortality. Patients who manifest elevated serum, vitamin B12, folic acid deficiency, basophilia greater than 3%, bone marrow chromosomal abnormalities and low leukocyte, alkaline phosphatase scores have responded poorly to corticosteroids. We have recently observed two patients with bronchial asthma who developed marked peripheral blood eosinophilia (16,500/cu mm and 6500/cu mm). Both had petechiae and purpura of the lower extremities, evidence of cardiac involvement, and pulmonary infiltrates. One patient had significant neurologic involvement. Associated with eosinophilia were elevated serum IgE levels (1400 IU/ml and 10,500 IU/ml), depressed serum C4 complement levels (13 mg/100 ml and 6 mg/100 ml), and high titers of rheumatoid factor (1:2560 and 1:640). Following treatment with 60 to 100 mg of prednisone daily for up to three weeks, both patients obtained remission of their disease. Eosinophil counts, serum IgE, and C4 complement levels returned to normal. Since then, both have been maintained on low-dose (10-20 mg), alternate-day prednisone with control of their symptoms. While our study has been limited to two patients, we feel that the observation of an elevated serum IgE may prognosticate a good response to corticosteroid therapy in the hypereosinophilic syndrome. ■

LUMBAR FUSION/continued

the physician most commonly sees, the role of fusion is at present not firmly established. Future research may define this role.

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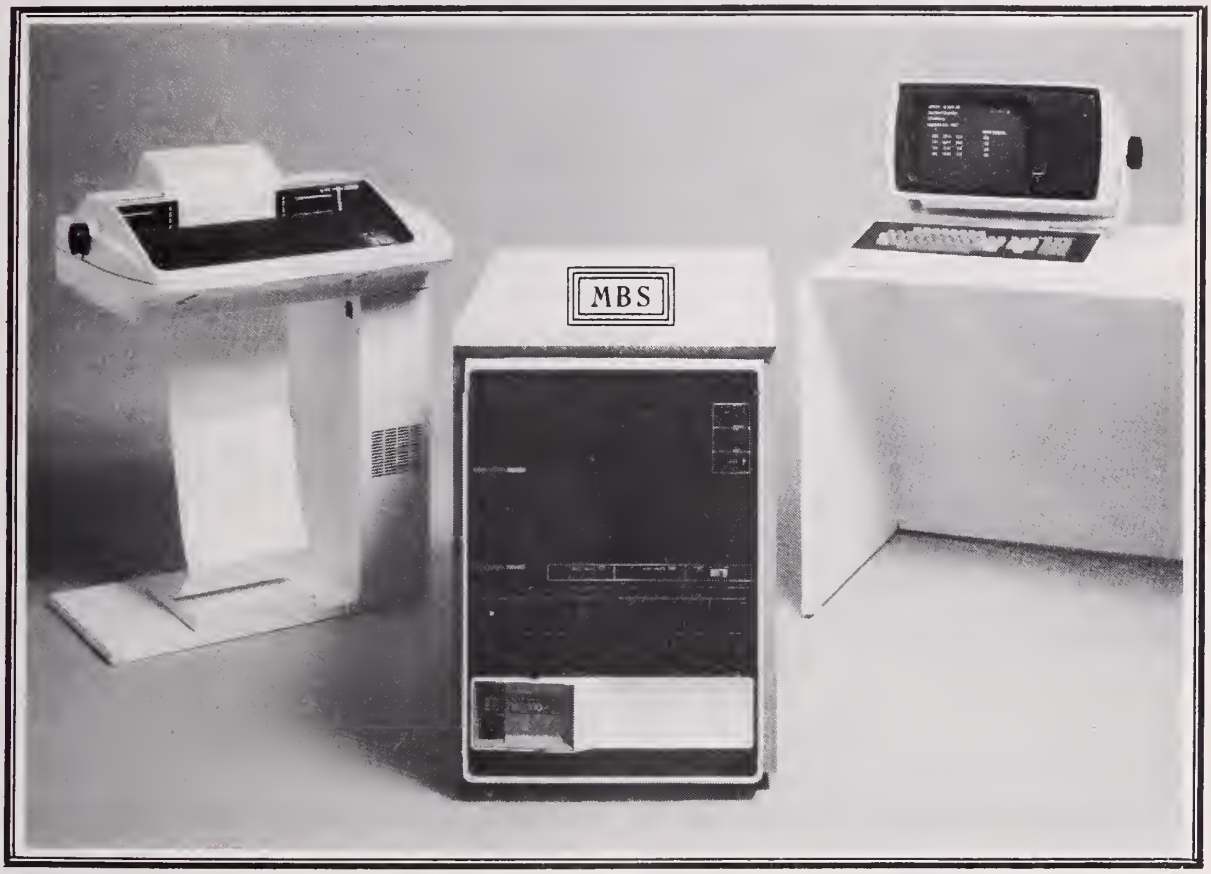

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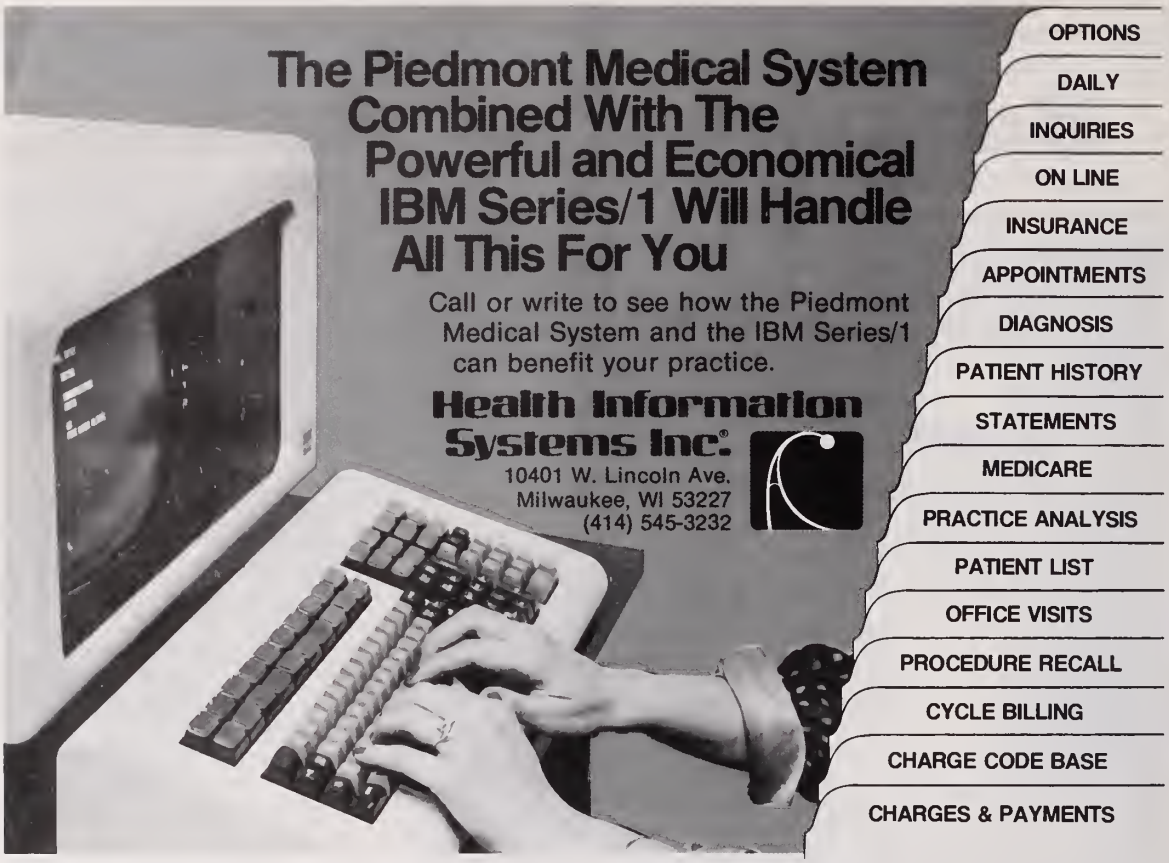

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President's Page

Darold A Treffert, MD

Yes, Virginia, there is no Santa Claus

I walked into Saint Agnes Hospital early one November morning, as usual, to make my rounds. Displayed prominently on the bulletin board among the CME course announcements, CPC schedules, and patient transfer notices was a clipping from the October 29, 1979 issue of *Medical Economics,* which I am sure most physicians in the state have seen by now, indicating Wisconsin's medical society dues to be the second highest in the country. While the quest to be number one seems to permeate all sorts of endeavors, probably that doesn't extend to this particular distinction. That clipping, and some letters I received subsequent to it, raises the same obvious question: How come?

Let me try to answer that entirely appropriate question.

First, Wisconsin chooses to maintain aggressive, pro-active, multiple-action programs in scientific, socio-economic, public education, legal and peer monitoring areas. Unfortunately, this programming is spread over relatively few physicians (4687) compared to the number of physicians in many larger states. Expenses for a medical society do not go up according to the number of doctors who are members, but rather go up according to the number of services provided, regardless of the number of members. Each state, whether having 4000 or 12,000 doctors, has only one Legislature to contend with, one Insurance Commissioner and one Department of Health and Social Services to deal with, and one Health Planning Agency to monitor and react to. In smaller states if a medical society is to be active and influential, activities to contend with the host of realities spawned by these governmental agencies are spread over a relatively small number of members, and the cost per member rises accordingly.

Secondly, for better or worse depending upon one's vantage point and the issue involved, Wisconsin government has a progressive, liberal tradition; and this state has served often as the beginning and testing ground of a variety of social benefit programs, including what many would conclude is progressive health programming (or intrusion), again depending upon one's vantage point. Because of this, for better or worse, Wisconsin probably has the most regulatory, most active H&SS Department in the country. Wisconsin has one of the highest percentages of citizens covered by health insurance and has the third most costly Medicaid program in the country. With each of these programs come regulations, regulations, and more regulations. It has a full time Legislature that considers over 3000 bills annually, at least 20% of which are health-related. It has one of the most complex and lengthy (for better or worse) health plans in the country which again spawns administrative regulations by the page-full. When it comes to the quality of our school systems, state park and recreational facilities, roads, and even our public health facilities themselves, we don't mind the "progressive tradition" of our state. However, when that same progressiveness extends to the healthcare system, frankly it costs money for SMS to keep up so that our medical practices can remain as unencumbered as possible. That's where a lot of the money goes!

Thirdly, compared to states with a similar number of physicians and a somewhat similar workload generated by active, progressive(?) legislatures and agencies, Wisconsin's dues are quite comparable. In Minnesota, for example, with 4873 members, dues are only $30 per year less. In states such as Michigan (with 9025 members), Illinois (13,590), Maryland (5425), Pennsylvania

Editor's note: The *Medical Economics* article refers to the 1979 dues of $320 and the 1978 membership of 4687.

(13,631), and Ohio (11,254), dues are less because, even though the total budget is only slightly higher than Wisconsin, that budget is spread over a much larger number of doctors. Even in this state it would help a great deal if the 1600 doctors who are not members of SMS, but practice in this state, would join SMS. If they did, our state dues would be $205 per member instead of $320. It seems hardly fair that those other 1600 physicians reap the same benefits as SMS members, such as in the activities enumerated above and from CME accrediting activities of SMS, yet they do not carry their fair share. But then, the world is full of people who don't carry their loads.

Fourthly, some states support their medical society through sizable revenue from sources other than dues income such as through insurance plans (Maryland, Florida), a trust income, or even a medical journal (Massachusetts). Wisconsin depends entirely upon dues revenue; it has no other outside revenue base.

Fifthly, at their present level dues are not out of proportion to those of a number of other organizations, employee groups, or professions. Since the average doctor works 50 hours per week, present state dues would average out to 12¢ per hour. According to my calculations, plumbers pay 20¢ per hour; retail clerks pay 6¢ per hour; railroad engineers pay 16¢ per hour; and nurses pay about 6¢ per hour. UAW workers pay two hours of salary every month to their union. Using present SMS dues and that formula, it would mean that the average hourly wage of a physician in Wisconsin would be $13.34. I suspect most of us do better than that. Now I realize that SMS dues are only one part of a more extensive dues package that most physicians pay when including county, national, and specialty society dues as well. But even at that I suspect the amount of income spent for dues by doctors, compared with other professions expressed as a percentage of income, is not out of line and in fact is probably quite less. Even if it were higher, which I suspect it is not, it seems like a very small price to pay, indeed, for the privilege of practicing medicine, and practicing it within a quality professional association framework and climate.

In short, you get what you pay for and you don't get what you don't pay for. There is no free lunch. Nor, in this matter, is there a Santa Claus. To present good programming in all these important areas of activity, on behalf of and for members, there must be adequate and good staff. Adequate staff and good staff do not come inexpensively. As I travel around the country and see and meet staffs of other state medical societies, I am continually impressed with the quality, knowledge, competence, and dedication of SMS staff through all of the SMS programs. To attract and retain such staff is, necessarily, costly. But it seems a good investment. Not just in ourselves, but rather in the interest of our patients and *their* health delivery system, *their* access to healthcare, *their* access to well-trained and contemporary practitioners, *their* protection from incompetency and quackery, *their* health education, and *their* continuing to have healthcare as a transaction between doctor and patient rather than a whole host of third-party intruders, be that government, insurance, inspectors, agencies, or regulators.

The health of Wisconsin citizens is too important to be left to government, agencies, regulators, and planners. It falls then to us, individually and collectively, to engage in all the above activities as well as maintaining our individual day-to-day practices. The best way to do that collectively, it seems to me, is through SMS. To do that will cost money. To do that well will cost even more. I suppose this sounds like a pep talk, a solicited testimonial, or what you'd expect the President to say. But it is none of these. It is a statement, a conviction, and a belief of why I feel we are an expensive organization, why I feel that expense is justified, and why I, along with you, choose to continue to belong. I too, as you, wish more of our dollars could go for the scientific and educational activities of our organization rather than socio-economic endeavors. I too, as you, wish more of our time and energies could go toward raising the level of healthcare in our state rather than merely trying to maintain some dignity and privacy in the transaction between doctor and patient that is being invaded daily by a whole host of would-be intruders, voyeurs, and regulators. I too long for a time when we can talk more to each other about science, research, and education rather than to so many others about costs and controls. I think, however, the only way to bring that about is to invest time, money, and energies in all the pressing issues of the present so as to make this a possibility once again. That will not happen in my time as President, and it will not happen in a vacuum or without effort. And it will not happen inexpensively.

It will not happen via Santa Claus. That leaves only us.

But medical society membership seems a good and worthwhile investment, not on our behalf but on behalf of those we choose to serve—our patients and their families. ■

Organizational SMS

Psychotherapy provisions delay endorsement of SuperRule

Due to significant problems contained in the mental health sections of the Medical Assistance SuperRule, the SMS Council November 17 withheld its endorsement of the document. The Council directed the Physicians Alliance Commission and staff "to work to eliminate the objectionable features and prepare an alternative course of action in order to offer guidelines to the membership prior to January 1, 1980."

The rule is expected to be published by January 1, 1980 with effective date of March 1, 1980. For several months, the Alliance has been concerned about psychotherapy provisions in the rule. Currently, the rule states that mild tranquilizers or sedatives which are provided solely for the purpose of relieving anxiety or insomnia are *not* covered services in a psychiatric facility, but are not prohibited as an outpatient service. Moreover, the rule does not cover "self-referrals" by providers which appear to include a provider referring a recipient to himself or herself as a practitioner acting in private practice. This provision prevents providers from treating walk-ons and could cause massive cross-referrals by psychiatrists. DHSS has stated that this clause does not cover *physicians* in private practice; an interpretation disputed by the Alliance due to the use of the above unresolved language in the rule.

SMS staff met with Don Percy, secretary of the Dept of Health and Social Services November 19 regarding the above stated problems in the rule. Mr Percy indicated he will support attempts to amend the rule where justified problems exist.

Meanwhile the Alliance staff is working with DHSS Secretary Percy and legislators to amend the rule via alternatives currently being investigated. The SMS Physicians Alliance will be sending a mailing to the SMS membership in December regarding the timetable, strategies, and proposed language changes in the rule.

More Council action November 17

In other action, November 17, the SMS Council:

- Reviewed a promotional videotape of the 1979 Work Week of Health Program, "Prospective Medicine: Rustproofing People," held October 10 at Sentry Insurance in Stevens Point.
- Approved retention of an actuary to provide immediate advice and assistance on recent assertions by the Wisconsin Insurance Commissioner that the Patients Compensation Fund is "broke" and thus requires major special assessments and imposition of an award cap of $500,000.
- Directed the SMS Commission on Governmental Affairs to assist in promulgating an administrative rule to permit school teachers and others to administer injections in emergency situations.
- Approved a joint proposal creating a statewide Impaired Physician Program between the State Medical Society of Wisconsin and the State Medical Examining Board. Under the proposal a Coordinating Council on Physician Impairment, consisting of three physicians from the SMS Commission on Mediation and Peer Review and three physicians from the Medical Examining Board, would establish policy and guidelines for the statewide Impaired Physician Program. The proposal also called for establishment of an Impaired Physician Committee under the SMS Commission on Mediation and Peer Review to identify and treat impaired physicians.
- Accepted a request from WisPRO to submit a nonmedical nominee to represent SMS on the WisPRO board.
- Appointed John Renner, MD, Madison, to the SMS Health Planning Commission; Thomas Dehn, MD, Milwaukee, to the Physicians Alliance Commission; William Maurer, MD, Marshfield, to the Public Information Commission; and appointed Kenneth J Dempsey, MD, Menomonee Falls, representing the Wisconsin Dermatological Society; Richard Harvey, MD, Madison, representing the Wisconsin Society of Physical Medicine and Rehabilitation; and Andrew B Crummy, MD, Madison, representing the Wisconsin Radiological Society to serve on the SMS Health Planning Commission. ■

Dr Jauquet appointed to HPC

Joseph M Jauquet, MD of Ashland has been appointed to the State Health Policy Council. SMS Secretary Earl R Thayer also was reappointed to the HPC. ■

Prepared by Diane Upton, Communications Coordinator for the State Medical Society.

Physicians recommend strict formaldehyde vapor standards

"The formaldehyde vapor exposure standards in mobile homes being recommended by the State are not strict enough and will result in needless cases of formaldehyde-related illness by Wisconsin residents this year," W W Schaefer, MD, Sheboygan, chairman of the State Medical Society's Committee on Mental Health, charged recently in a state newspaper story.

The SMS committee has recommended that the limit on formaldehyde vapors in mobile homes be set at 0.1 parts per million of air. Joseph Noll, secretary of the Wisconsin Dept of Industry, Labor and Human Relations, has said he will recommend a 0.4 ppm standard the first year and a 0.2 ppm standard the year after.

Urea formaldehyde is used as a glue in building materials such as plywood and particle board used extensively in mobile homes. As the glue dries, it releases formaldehyde fumes. In addition, formaldehyde is present in some types of foam insulation.

In a letter to the Society committee, Noll defended his stance by stating that the 0.1 ppm standard was not measurable.

"Mr Noll says the 0.1 ppm standard is not measurable, yet a recent study of formaldehyde vapor exposure in homes by the State Division of Health has successfully measured formaldehyde levels down to 0.1 ppm and lower," Doctor Schaefer said.

The study, conducted by Carl Zenz, MD, a member of the SMS Environmental Health Committee, and Mary Ann Woodbury of the Division of Health, involved investigations of complaint cases received by the Division of Health from physicians, public health agencies, and consumers.

According to the field study, between January 1, 1978 and January 25, 1979, there were reports of formaldehyde-related illnesses in 56 homes involving 107 people, with the average formaldehyde vapor level at 0.42 ppm. Several of the individuals involved reported symptoms including eye irritation, cough, sore throat, or runny nose; shortness of breath or tightness of chest; headache; fatigue; vomiting, and diarrhea.

In addition, 6 of 11 infants in the affected homes required hospitalization for gastrointestinal problems or respiratory problems. In each case, the symptoms decreased or stopped when the infant was removed from the house and returned when the infant was returned to the home. The study recommends setting an interim standard of 0.1 ppm.

"Statistics like these underline the necessity for a strict standard," Doctor Schaefer said referring to the Division of Health study. "What good will a 0.4 ppm standard be the first year when this is the average formaldehyde level found in the complaint cases?"

"Many European countries have a maximum formaldehyde exposure standard for human dwellings set at 0.1 ppm," he said. "Moreover, the American Industrial Hygiene Association also has recommended the 0.1 ppm standard." ■

CONTRIBUTIONS CES FOUNDATION OCTOBER 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1979.

Unrestricted

Marathon County Medical Auxiliary; Winnebago County Medical Auxiliary; Jefferson County Medical Auxiliary; SMS Members—*Voluntary Contributions*

Restricted

Anthony J Sanfelippo—*Aesculapian Society Membership*

Wisconsin Physicians Service—*Medical Student Summer Externship*

Memorials

Dr-Mrs Donald J Gallagher; Brown County Medical Auxiliary; Dr-Mrs Robert T Schmidt—*Ralph Lenz, MD (Brown County Loan Fund)*

Dr-Mrs Robert T Schmidt; Dr-Mrs Stephen D Austin—*Ralph Troup, MD (Brown County Loan Fund)*

Dr-Mrs Robert T Schmidt—*Miss Bess Levitas; Mrs Ida Arends; Mrs Lydia Dollar (Brown County Loan Fund)*

Dr-Mrs Robert G Zach-*Patrick Mills (Aesculapian Society)*

Eau Claire-Dunn-Pepin County Medical Auxiliary—*Margie Willison*

William G Wendle—*RH Wasserberger, MD*

Dr-Mrs John E Dettmann—*Ralph Lenz, MD; Ralph Troup, MD*

Dr-Mrs Jewel Huebner—*Frank J Eibl*

Dr-Mrs EJ Nordby—*Otto A Mortensen, MD*

Dr-Mrs John R Guy—*EB Davies, MD; Alphonse Richter*

Alert to members: Resolution deadline for Annual Meeting

The 1980 House of Delegates sessions will be held March 27-29. All resolutions must be submitted in proper form to the Secretary's office at SMS no later than Friday, January 25, 1980 (two months prior to the first session of the House). It is important that county medical societies, specialty sections, and members submit resolutions early to facilitate early distribution of materials and allow all delegates to adequately represent their county medical society or specialty section. If a resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS staff is available to assist in preparation of fiscal notes. ■

SMS urges changes in involuntary commitment standards

Two proposals to amend current procedures for involuntary commitment in Wisconsin have been endorsed by the Society's Committee on Mental Health and the SMS Commission on Governmental Affairs.

Present law requires evidence of a "very substantial probability" of harm to the individual as one of the factors to allow commitment. Under AB 848, introduced by Rep John Shabaz (R-New Berlin), "recent proof" which indicates inability by an individual to satisfy essential personal needs would be sufficient to permit commitment under court supervision.

Another version of the bill, AB 913, would permit "substantial probability" of physical harm to oneself as "evidenced by recent overt acts," as cause for commitment.

Both bills have been endorsed by the State Medical Society. According to SMS Mental Health Committee Chairman Charles Landis, MD, Milwaukee, both bills would constitute a significant improvement over the present law and would help to correct current deficiencies in the commitment statutes "which prevent mentally ill patients from obtaining medical treatment they desperately need."

Although supportive of both bills, the SMS Mental Health Committee sees them as being halfway solutions to a much larger problem. The committee will propose its own corrective legislation regarding the involuntary commitment standards in January. ■

SMS staff tours AMA

The President-elect of SMS and 41 State Medical Society of Wisconsin staff persons got a first-hand look at the activities and structure of the American Medical Association November 6 when they visited the organization's headquarters in Chicago.

All were given an overview of the AMA's organization and programs by AMA-EVP James Sammons, MD and Senior Vice Presidents Whalen Strobhar, Theodore Chilcoat, Thomas Hannon, and Group Vice President Leonard Fenninger, MD.

During the afternoon, individual conferences were held between SMS and AMA staff in similar program areas. The AMA visit proved to be an educational experience for SMS staff who gained a better understanding of AMA programs, structure and staff, and how to make use of AMA services at the state society level.

The trip marked the first time that an entire state or county medical society staff had visited the AMA. ■

CONTRIBUTIONS CES FOUNDATION SEPTEMBER 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1979.

Unrestricted

George H Handy, MD—*Voluntary Contribution*

Restricted

T Z Garman, MD—*Museum of Medical Progress*

Memorials

Mrs Stephen D Austin—*Ralph B Lenz (Brown County Student Loan Fund)*

General Clinic of West Bend Physicians—*Mrs Florence Nielson*

Dr-Mrs Leslie Jones—*Anna B Pedi*

State Medical Society—*Sarkis H Kash, MD; James R Weir, MD; Bernard J Werra, MD*

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Alternative to x-ray bill endorsed

The SMS Commission on Governmental Affairs has given its approval to an alternative proposal to AB 824, the x-ray certification bill. The proposal, drafted by an ad hoc committee of physicians, dentists, and radiologic technologists, calls for upgrading the Dept of Health and Social Services' (DHSS) current inspection program of x-ray facilities and equipment.

Under the new proposal, DHSS would inspect all x-ray facilities at least once every two years, and the individual examining boards—medical, dental, and chiropractic—would each have the option of establishing its own minimum standards for operating x-ray machines. In the original bill, a "super-advisory committee" would develop the certification standards including a mandatory proficiency test for x-ray machine operators.

The substitute proposal also calls upon the Radiation Protection Council to monitor the number of x-rays being used by physicians, dentists, and chiropractors and make appropriate recommendations to the examining boards regarding x-ray use.

In other action, the Governmental Affairs Commission:

- Endorsed AB 942 which would permit the inclusion of emergency medical information about the licensee on the back side of drivers' licenses.

- Supported in principle AB 513 and SB 197 restricting the manufacturing and sale of drug paraphernalia.

- Supported in principle AB 779, the Natural Death Act, which authorizes withholding or withdrawing extraordinary means of artificial life support from terminally ill individuals when the individual has executed a formal written directive to that effect. The Commission suggested that the bill require the patient as well as the physician to keep a copy of the directive to prevent full liability from resting with the physician.

- Appointed a committee chaired by Chesley Erwin, MD, Milwaukee, to study the existing system of death investigation and criteria for medical examiners in Wisconsin in order to make recommendations to the 1981 Legislature. ■

New medical protection plan for members to take effect

SMS Services, Inc recently concluded negotiations resulting in the endorsement of the new SMS Medical Protection Plan for members of the Society. Offering significantly improved health insurance benefits over the old WPS Plan 3 for the same premium dollar, the new Medical Protection Plan is underwritten by Blue Cross—Surgical Care and becomes effective on December 1, 1979.

Evaluation of the health insurance benefit package for members has been going on for the past two years, and the decision to move to a new insurance carrier for the SMS membership group was based on the following: 1) membership requests for a better and broader program of protection [this resulted in the adoption of WPS Plan 3 in 1978 and its ultimate improvement this year in the form of the new Medical Protection Plan]; 2) better benefits for the premium dollar; 3) the need, as demonstrated by the declining enrollment over the past six years, for a stronger promotional effort; and 4) inability to obtain adequate assurances from WPS to continue providing full semi-private coverage in the hospital and to continue waiving age and area rating.

Members who hold policies under WPS Plans—Plan 1, Plan 2 or Plan 3—were notified of the new Medical Protection Plan in a letter dated November 7, 1979. They have the option of retaining their present coverage with WPS or converting to the new and improved coverage. The benefits of the new plan will be offered to all other SMS members by open enrollment in the near future. Physicians who wish further information should contact Peter Wood at SMS offices in Madison: regular number (608) 257-6781; toll-free number 1-800-362-9080. ■

SMS to sponsor conference on child health

"Policies and Politics of Children's Health and Safety" is the title of the February 29, 1980 conference to be held in Milwaukee sponsored by the State Medical Society, the Wisconsin Chapter of the American Academy of Pediatrics, the Center for Public Representation, and the Center for Consumer Affairs of UW-Milwaukee. The following topics will be addressed: health education and screening in schools, child abuse and neglect, perinatal and infant health, safety and accident control, alcoholism and drug abuse, and teenage pregnancy and family planning. The conference will be aimed at health professionals; school administrators and instructors; and legislative, departmental, and community action health program staff. ■

Physicians appointed to decertification advisory committee

The SMS Commission on Health Planning reports that 11 physicians, most of whom were recommended by the State Medical Society, have been selected to serve on the General Advisory Committee on Administrative Procedures for Decertification Rule Development. The 41-member advisory committee is composed of physicians, nurses, hospital administrators, health systems agency directors, financial managers, consumers, methodology specialists, and Division of Health staff.

The physicians are: John Manley, Milwaukee; Dean Emanuel, Marshfield; James E Aure, Milwaukee; A Erik Gundersen, LaCrosse; Maurice Greenberg, Milwaukee; John Mokrohisky, Green Bay; Allan B Levin, Madison: Perry A Henderson, Madison; David Pringle, Stevens Point; Daniel T Kincaid, Eau Claire; and Dolores A Buchler, Madison. ■

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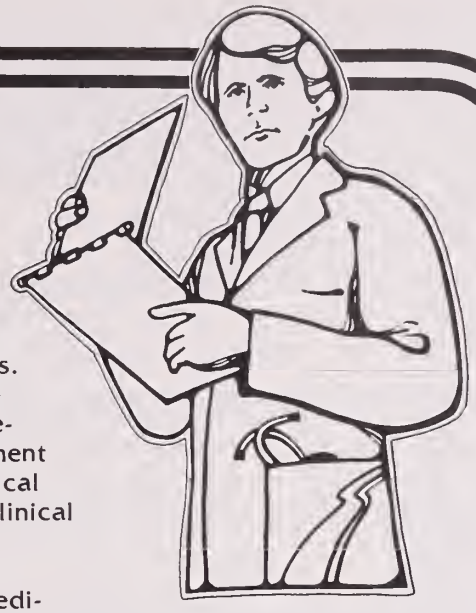

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Legislative scorecard

The Wisconsin Legislature adjourned November 2 after addressing several of the 1,500 plus individual proposals introduced to date. The session was a highly successful one from the standpoint of SMS, and listed below are some of the major health-related bills and their status at the end of the session:

• **MANDATORY CHIROPRACTIC COVERAGE**—Senate Bill 30, a proposal mandating chiropractic coverage in all health and disability policies in Wisconsin was indefinitely postponed by the State Senate October 2. The Senate also voted down a motion to reconsider the measure to kill the bill for the session. The Assembly Financial Institutions Committee has recommended support of a similar bill, AB 203 which is currently in the Joint Finance Committee. SMS opposes both bills.

• **DETERMINATION OF DEATH**—The Senate Human Services Committee has recommended indefinite postponement of this bill which states that an individual is dead for legal and medical purposes when there is irreversible cessation of all functioning of the brain. Committee Chairman Carl Thompson (D-Stoughton) now has the option of leaving the bill in committee or reporting it out for floor debate. SMS has endorsed SB 181.

• **NURSE-MIDWIFERY**—Bill sponsor Senator Paul Offner (D-LaCrosse) has amended the bill to include language requested by the SMS Governmental Affairs Commission that the practice of nurse-midwifery must occur within the scope of a written contractural agreement between a nurse-midwife and a physician. The Commission on Governmental Affairs is working with Senator Offner on further changes including the deletion of language authorizing nurse-midwives to provide perinatal, inter-conceptional and family planning care for both mother and the newborn and instead substituting language allowing "provision of perinatal care for the mother and immediate care for the newborn." The Commission also is concerned that the bill make some mention of the practice of nurse-midwifery occur under the supervision of a physician. SB 373 is currently in the Assembly Health & Social Services Committee.

• **MANDATORY PSYCHOLOGY COVERAGE**—Originally scheduled for Assembly floor debate on October 30, the State Assembly deferred action on the bill which would require health insurers to cover services of clinical psychologists if coverage is extended for similar services by physicians. The bill has been rescheduled for the first day of next legislative session—January 29, 1980. SMS opposes the bill.

• **DISCOVERY IN MEDICAL MALPRACTICE ACTIONS**—Assembly Bill 326 dealing with statute of limitations for malpractice actions passed the Senate Assembly 77-20 after the SMS Physicians Alliance successfully had the bill amended to allow malpractice actions to be initiated within three years of the incident or one year from the discovery of injury, not to exceed *five* years (or age ten, whichever is later for minors) from the date the injury occurred. Originally the bill called for expanding the statute of limitations to *six* years. SMS will attempt in the Senate to reduce the discovery limitations to *four* years. Present Wisconsin laws do not have a discovery clause.

The State Legislature will resume action on January 29, 1980. That floor period will last until April 3, 1980 and will be the last opportunity for the Legislature to act on pending bills this biennium. Additional information on the above or other bills may be obtained by contacting SMS legislative coordinators Don Lord or Mike Brozek toll-free: 1-800-362-9080 or 608-257-6781. ■

REFUGEE RELIEF GROUP

Physicians are requested to donate medical surplus, medical and surgical supplies, and money to a Milwaukee-based Indochina Relief Group currently engaged in establishing a field hospital in a Thailand refugee camp.

The group, called the Wisconsin Indochina Refugee Relief, Inc, is working with the Medical College of Wisconsin in organizing a medical team to travel to Thailand during 1980. Physicians are asked to volunteer for at least a one-month period and should submit a complete resume, including the time period during which they can serve, to William Coleman, MD, Professor of Preventive Medicine, Medical College of Wisconsin, PO Box 26509, Milwaukee, WI 53226.

Physicians who wish to donate medical or surgical supplies should contact the Wisconsin Indochina Refugee Relief, Inc (WIRR) office at (414) 257-8347 to make arrangements for sending the supplies. A list of needed medical-surgical supplies can be obtained from the WIRR office.

In therapy of skin and skin structure infections due to susceptible strains of staphylococci and/or streptococci...

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(CEFADROXIL MONOHYDRATE)

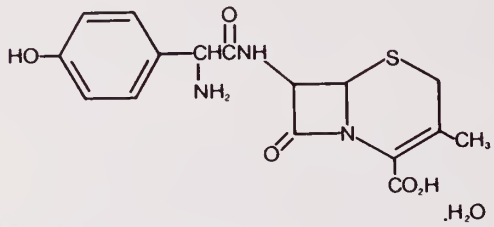
DURICEF®

(CEFADROXIL MONOHYDRATE)

References:

1. Data on file, Mead Johnson Pharmaceutical Division.
2. Gatley MS: To be taken as directed. *J Ray Coll Gen Pract* 16:39, 1968.

DESCRIPTION: DURICEF® (cefadroxil monohydrate) is a semisynthetic cephalosporin antibiotic intended for oral administration. It is a white to yellowish-white crystalline powder. It is soluble in water and it is acid-stable. It is chemically designated as 7-[[D-2-amino-2-(4-hydroxyphenyl)acetyl]amino]-3-methyl-8-oxo-5-thia-1-azabicyclo [4.2.0]oct-2-ene-2-carboxylic acid monohydrate. It has the following structural formula:



Clinical Pharmacology–DURICEF (cefadroxil monohydrate) is rapidly absorbed after oral administration. Following single doses of 500 and 1000 mg., average peak serum concentrations were approximately 16 and 28 mcg./ml., respectively. Measurable levels were present 12 hours after administration. Over 90 percent of the drug is excreted unchanged in the urine within eight hours. Peak urine concentrations are approximately 1800 mcg./ml. during the period following a single 500 mg. oral dose. Increases in dosage generally produce a proportionate increase in DURICEF urinary concentration. The urine antibiotic concentration, following a 1 gm. dose, was maintained well above the MIC of susceptible urinary pathogens for 20 to 22 hours.

MICROBIOLOGY: *In vitro* tests demonstrate that the cephalosporins are bactericidal because of their inhibition of cell-wall synthesis. DURICEF is active against the following organisms *in vitro:*

- *Beta-hemolytic streptococci*
- *Staphylococci*, including coagulase-positive, coagulase-negative, and penicillinase-producing strains
- *Streptococcus (Diplococcus) pneumoniae*
- *Escherichia coli*
- *Proteus mirabilis*
- *Klebsiella* species

Note–Most strains of *Enterococci (Streptococcus faecalis* and *S. faecium)* are resistant to DURICEF. It is not active against most strains of *enterobacter species, P. morganii,* and *P. vulgaris.* It has no activity against *Pseudomonas* or *Herella species.*

Disc Susceptibility Tests–Quantitative methods that require measurement of zone diameters give the most precise estimates of antibiotic susceptibility. One recommended procedure (CFR Section 460.1) uses cephalosporin class disc for testing susceptibility; interpretations correlate zone diameters of the disc test with MIC values for DURICEF. With this procedure, a report from the laboratory of "resistant" indicates that the infecting organism is not likely to respond to therapy. A report of "intermediate susceptibility" suggests that the organism would be susceptible if the infection is confined to the urinary tract, as DURICEF produces high antibiotic levels in the urine.

INDICATIONS: DURICEF (cefadroxil monohydrate) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

- Urinary tract infections caused by *E. coli, P. mirabilis,* and *Klebsiella* species
- Skin and skin structure infections caused by staphylococci and/or streptococci

Note–Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATION: DURICEF (cefadroxil monohydrate) is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE.)

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil monohydrate).

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil monohydrate) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

USAGE IN PREGNANCY: Although no teratogenic or anti-fertility effects were seen in reproductive studies in mice and rats receiving dosages greater than the normal human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

ADVERSE REACTIONS: Gastrointestinal–The most frequent side-effect has been nausea. It was infrequently severe enough to warrant cessation of therapy. Administration with food decreases nausea and does not decrease absorption. Diarrhea and dysuria have also occurred.

Hypersensitivity–Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

DOSAGE AND ADMINISTRATION: DURICEF (cefadroxil monohydrate) is acid stable and may be administered orally without regard to meals. Administration with food may be helpful in diminishing potential gastrointestinal complaints occasionally associated with oral cephalosporin therapy.

Adults–For urinary tract infections the usual adult dosage is one gm. (two 500 mg. capsules) two times per day. For skin and skin structure infections the usual dose is 500 mg. two times per day or 1 gm. once a day.

In patients with renal impairment, the dosage of cefadroxil should be adjusted according to creatinine clearance rates to prevent drug accumulation. The following schedule is suggested. In adults, the initial dose is 1 gm. of DURICEF (cefadroxil monohydrate) and the maintenance dose (based on the creatinine clearance rate [ml/min/1.73M²]) is 500 mg. at the time intervals listed below.

Creatinine Clearances	Dosage Interval
0-10 ml/min	36 hours
10-25 ml/min	24 hours
25-50 ml/min	12 hours

Patients with creatinine clearance rates over 50 ml/min may be treated as if they were patients having normal renal function.

Children–Dosage and safety have not yet been established in children.

HOW SUPPLIED: DURICEF® (cefadroxil monohydrate) capsules 500 mg. for oral administration in an opaque maroon cap and opaque white body No. 0 hard gelatin capsule. On each half capsule printed in black is "MJ" and "500." Available in bottles of 24 capsules (NDC 0087-0784-41) and 100 capsules (NDC 0087-0784-42).

U.S. Patent Re. 29,164

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Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of November 9, 1979

NEW MEMBERS

County Medical Society

ASHLAND-BAYFIELD-IRON

Hamp, James A, Rte #1, Box 163 S, Ashland 54806 (1947, Regular, Otorhinolaryngology)

CLARK

Gregorio, Federico P, 216 Sunset Pl, Neillsville 54456 (1946, Regular, General Surgery)
Janssen, Gary J, 134 S Main St, Greenwood 54437 (1944, Regular, Family Physician, Certified)

DANE

Green, Joseph M, 600 Highland Ave, Madison 53792 (1925, Regular, Child Psychiatry/Psychiatry, Certified-P)
Jones, Judson E, 2132 Allen Blvd, Middleton 53562 (1952, Resident, Obstetrics and Gynecology)
Liebow, Mark F, 1431 Morrison St, Madison 53703 (1953, Resident, Internal Medicine)
Miller, Gary T, 62 Hollywood Dr, Madison 53713 (1950, Resident, Otorhinolaryngology)
Schnitzler, Eugene R, 30 S Henry St, Madison 53703 (1945, Regular, Pediatrics/Neurology, Certified-PD)
Schwartz, David B, H4 639 CSC, 600 Highland Ave, Madison 53792 (1941, Regular, Obstetrics and Gynecology)
Selliken, Joseph Jr, 213 N Brooks St, Madison 53715 (1945, Resident, Pathology/Emergency Medicine)
Thom, Michael L, 30 S Henry St, Madison 53703 (1949, Regular, Internal Medicine)
Thorner, Brooke J, 2533 Kendall Ave, Madison 53705 (1952, Resident, Psychiatry)
Wilson, Henry M, 30 S Henry St, Madison 53703 (1948, Regular, Internal Medicine/Nephrology, Certified-IM)

EAU CLAIRE-DUNN-PEPIN

Feigal, Michael D, 2211 Stout Rd, Menomonie 54751 (1949, Regular, Family Physician, Certified)
Finkel, Michael F, 733 W Clairemont Ave, Eau Claire 54701 (1947, Regular, Neurology, Certified-P)
Folkestad, Charles L, 2211 Stout Rd, Menomonie 54751 (1949, Regular, Family Physician, Certified-FP)
Narotzky, Robert A, 733 W Clairemont, Eau Claire 54701 (1950, Regular, Neurological Surgery)
Reid, Dale L, 733 W Clairemont Ave, Eau Claire 54701 (1950, Regular, Family Physician)

KENOSHA

Sharma, Venkata K, 1322 Clover Lane, Libertyville, IL 60048 (1947, Regular, Psychiatry)
Ziarko, Mitchell Jr, 1015 65th St, Kenosha 53140 (1949, Regular, Internal Medicine, Certified)

LACROSSE

Counihan, Colleen M, 2109 S 7th St, LaCrosse 54601 (1951, Resident, Internal Medicine)
Dahlberg, Philip J, 1836 South Ave, LaCrosse 54601 (1947, Regular, Internal Medicine/Nephrology, Certified-IM)

MARATHON

Block, Joel H, 2727 Plaza Dr, Wausau 54401 (1949, Regular, Radiology)
Comstock, Michael K, 209 Wood St, Rothschild 54474 (1946, Regular, Anesthesiology)
Freeman, Mary Jo, 1840 County Trunk XX, Mosinee 54455 (1949, Regular, Internal Medicine)
Taylor, Geoffrey, 2727 Plaza Dr, Wausau 54401 (1929, Regular, Allergy, Certified)

MILWAUKEE

Boex, Robert M, 2820 Cambridge Circle, Brookfield 53005 (1948, Regular, Diagnostic Radiology, Certified-R)
Bonelli, Landy E, 1434 N 122nd St, Wauwatosa 53226 (1948, Regular, Emergency Medicine)
Boxer, Richard J, 1218 W Kilbourne St, Milwaukee 53233 (1947, Regular, Urology)
Bryant, John M, 525 E Wells St, Milwaukee 53202 (1950, Regular, Internal Medicine)
Caimacan, Dumitru T, 2020 E Park Pl, Milwaukee 53211 (1925, Regular, General Practice)
Calimlim, Jefferson, 2388 N Lake Dr, Milwaukee 53211 (1944, Regular, Otorhinolaryngology/Head and Neck Surgery)
Derderian, Harry, 751 Amy Belle Lake Rd, Hubertus 53033 (1951, Resident, Orthopedic Surgery)
Ethington, James E, 2388 N Lake Dr, Milwaukee 53211 (1948, Regular, Dermatology)
Fisk, Albert A, 2711 W Wells St, Milwaukee 53208 (1921, Regular, Geriatrics/Internal Medicine, Certified-IM)
Graber, John N, 8700 W Wisconsin Ave, Milwaukee 53226 (1950, Resident, General Surgery)
Kumar, Ullattil N, 8842 Garden Lane, Greendale 53129 (1947, Regular, Internal Medicine/Pulmonary Diseases, Certified-IM)
Lee, Ning, 8700 W Wisconsin Ave, Milwaukee 53226 (1949, Resident, Pathology)
Moy, Raymond W, 3531 W Burleigh St, Milwaukee 53210 (1952, Regular, Family Physician)
Paegle, Roland D, 10201 W Nash St, Wauwatosa 53216 (1936, Regular, Pathology/Clinical Pathology, Certified, PTH)
Paz, Edward, 3501 S Howell Ave, Milwaukee 53207 (1940, Regular, Internal Medicine)
Phillips, Michael, 9401 W Wisconsin Ave, Milwaukee 53226 (1950, Resident, Pathology)
Shivaram, Mysore S, 2388 N Lake Dr, Milwaukee 53211 (1950, Regular, Orthopedic Surgery)
Tokars, Jerome I, 4035 S 84th St, Greenfield 53228 (1950, Regular, Internal Medicine)
Walrath, Daniel L, 3414 W Wisconsin Ave, Milwaukee 53208 (1953, Resident, Family Physician)
Yale, Russell S, 2015 E Newport, Milwaukee 53211 (1947, Regular, Otorhinolaryngology/Plastic Surgery)

ONEIDA-VILAS

Erickson, Scott S, 1020 Kabel Ave, Rhinelander 54501 (1949, Regular, Internal Medicine, Certified)
Loes, Peter L, 415 W Prospect St, Rhinelander 54501 (1948, Regular, Obstetrics and Gynecology)

OUTAGAMIE

Butitta, John M, 401 N Oneida St, Appleton 54911 (1950, Regular, Internal Medicine)
Geall, Michael G, 900 E Grant St, Appleton 54911 (1938, Regular, Gastroenterology/Internal Medicine, Certified-IM)
Grant, Douglas H, 401 N Oneida St, Appleton 54911 (1946, Regular, Family Physician)
Hagens, Jerome H, 1260 Valley Rd, Appleton 54911 (1941, Regular, Orthopedic Surgery, Certified)
Kim, Jin Sik, 401 Oneida St, Appleton 54911 (1945, Regular, Obstetrics and Gynecology)
Lindstrom, John R, 900 E Grant St, Appleton 54911 (1946, Regular, Orthopedic Surgery, Certified)

RACINE

Larmore, Gerry K, 190 Gardner, Burlington 53105 (1949, Regular, Family Physician)
Strimling, Arnold M, 3733 South Lane, Franksville 53126 (1941, Regular, Radiology/Nuclear Medicine, Certified-R)

ROCK

Krembs, F Gregory, 101 S Main St, Janesville 53545 (1943, Regular, Psychiatry/Neurology)
Lloyd, Brian E, 152 Locust, Janesville 53545 (1941, Regular, Psychiatry, Certified)
Peterson, Daniel T, 580 N Washington, Janesville 53545 (1946, Regular, Internal Medicine, Certified)

RUSK

Chatterton, Howard T, 906 College Ave, W, Ladysmith 54848 (1947, Regular, Family Physician)
Nash, Richard G, 906 College Ave, W, Ladysmith 54868 (1949, Regular, Family Physician)

WASHINGTON

Gill, Lawrence A, 1201 Oak, West Bend 53095 (1950, Regular, Family Physician)
Griswold, Bruce G, 615 Arthur Place, West Bend 53095 (1949, Regular, Family Physician)
Ninneman, Robert W, 279 S 17th Ave, West Bend 53095 (1950, Regular, Internal Medicine)

WAUPACA

Burgstede, Gilbert C, 710 Riverside Dr, Waupaca 54981 (1950, Regular, Family Physician)

WINNEBAGO

Christopherson, D L, 411 Lincoln St, Neenah 54956 (1947, Regular, Family Physician, Certified)
Plueddeman, Paul M, Rte 2, Box 300A, Ripon 54971 (1931, Regular, Family Physician/Emergency Medicine, Certified-FP)

WOOD

Aberman, David R, 1000 N Oak Ave, Marshfield 54449 (1947, Regular, Obstetrics and Gynecology)
Campbell, John A, 1000 N Oak Ave, Marshfield 54449 (1940, Regular, Internal Medicine/Pulmonary Diseases, Certified-IM)
Edwards, William R, 1000 N Oak Ave, Marshfield 54449 (1952, Resident, Internal Medicine)
Ejercito, Victor S, 1000 N Oak Ave, Marshfield 54449 (1948, Regular, Otorhinolaryngology)
Harkins, Paul G, 1000 N Oak Ave, Marshfield 54449 (1948, Regular, Obstetrics and Gynecology)
Johnson, Gary A, 1000 N Oak Ave, Marshfield 54449 (1948, Resident, Internal Medicine)
Liss, Paul L, 1000 N Oak Ave, Marshfield 54449 (1950, Regular, Internal Medicine)
Phillips, Robert E, 1000 N Oak Ave, Marshfield 54449 (1949, Regular, Internal Medicine, Certified-IM)
Ries, Peter M, 621 N Plum, Marshfield 54449 (1952, Resident, Internal Medicine)
Sullivan, Bradley J, 1000 N Oak Ave, Marshfield 54449 (1945, Regular, Pediatrics)
Yun, Moon Gil, 1000 N Oak Ave, Marshfield 54449 (1947, Regular, Anesthesiology)

CHANGE OF ADDRESS

(Does not include those within a city)

COLUMBIA-MARQUETTE-ADAMS

Grose, Charles D, Portage, to 855 N Camino Cordon, Tucson, AZ 85710

DANE

Cooper, Garrett A, Madison, to 301 Circulo De La Paladins, Green Valley, AZ 85614
Holden, Richard C, Madison, to 123 Hospital Drive, Watertown 53094

FOND DU LAC

Wojta, William C, Fond du Lac, to 405 North Ocean Blvd, Pompano Beach, FL 33062

FOREST

Ovitz, Ernest G, Laona, to 730 McCall Rd, Englewood, FL 33533

LACROSSE

Blain, Claude A, LaCrosse, to 303 West Riverside Dr, Carlsbad, NM 88220
Rymer, Robert A, LaCrosse, to 2236 Ridgeview Rd, Columbus, OH 43221

LANGLADE

Curran, William P, Deerbrook, to 2821 SW 4th St, Boynton Beach, FL 33435

MILWAUKEE

Holbrook, Arthur A, Milwaukee, to 1633 Boathouse Circle, Sarasota, FL 33581

RACINE

Bacon, Glenn A, Racine, to 304 South 22nd St, Temple, Tx 76501

WAUKESHA

Schuler, William E, Waukesha, to 1411 Lakewood Dr, Mendota, IL 61342

WINNEBAGO

Ledbetter, Marion K, Neenah, to 1345 Thoren Lane, Rockford, IL 61110

DEATHS

Sharp, Darrell S, Trempealeau-Jackson-Buffalo County, October 2, 1979
Davies, Evan B, Waukesha County, October 17, 1979
Mortensen, Otto A, Dane County, October 18, 1979
Schloemer, Howard F, Waukesha County, October 19, 1979
Kelm, George J, Waukesha County, November 1, 1979 ■

County Societies

ASHLAND-BAYFIELD-IRON: The Tri-County Medical Society of Ashland, Bayfield, and Iron counties has established a public information committee to give citizens of these counties information regarding health issues. John C Oujiri, MD,* Ashland, has been named chairman of the public information committee and also as media liaison person for the Tri-County Medical Society.

The medical society, through its new public information committee, intends to inform citizens about health hazards and health maintenance procedures so they may take a more active role in their own health care and improve the general health of their communities.

Herbert Sandmire, MD,* Green Bay, chairman of the SMS Commission on Public Information, reminds county societies of the importance of initiating local, functioning public information committees and urges counties that have not already done so to establish a committee in their area.

CLARK: New officers of the Clark County Medical Society are MDs A Mitat Algan,* Loyal, president; N Neelagaru,* Neillsville, secretary; B O Gungor,* Neillsville, delegate; and R V Reddy,* Neillsville, alternate delegate.

LACROSSE. LaCrosse County Medical Society officers for the year 1980 are as follows: MDs David E Goodnough,* anesthesiologist at Gundersen Clinic, president; George P Gersch,* family physician at Skemp-Grandview-LaCrosse Clinic in West Salem, president-elect; and Thomas P Lathrop,* internist, Gundersen Clinic, will be secretary-treasurer. ■

Specialty Societies

Wisconsin Neurosurgical Society: Officers of the Wisconsin Neurosurgical Society elected in October during the Annual Meeting in Oshkosh are: MDs William F Bingham, LaCrosse, president; Ralph L Suechting,* Neenah, president-elect; Richard Strassburger,* Milwaukee, vice-president; and George R Bartl,* Waukesha, secretary-treasurer. ■

*Physician members of the State Medical Society of Wisconsin.

Obituaries

◈County, State, AMA Members

◈ **Ralph B Lenz, MD,** 72, De Pere, died Sept 15, 1979 in De Pere. Born Jan 2, 1907 in Green Bay, Doctor Lenz graduated from Marquette University School of Medicine in 1934. He practiced medicine in De Pere from 1935 until his retirement in 1978. He was a member of the International College of Surgeons. Surviving are his widow, Jane: two daughters, Mrs Gerald (Nancy) Kosnar, De Pere, and Mrs James A (Linda) Felber of Fox Point, Wis.

◈ **Ralph Leslie Troup, MD,** 82, Green Bay, died Sept 29, 1979 in Oshkosh. Born Nov 26, 1896 in Council Bluffs, Iowa, Doctor Troup graduated from the University of Nebraska Medical School in 1921, and had

1980 VACATION TOURS

ARE YOU THINKING about your 1980 vacation plans? SMS Services, Inc has arranged for two tours—the first, in February, will go to Puerto Vallarta, Mexico; the second, in the fall, will go to Bavaria and Oberammergau Passion Play. The tours will be managed by Dittmann Tours.

Escape February's cold this winter and bask in the sun surrounded by the white-white sand, palms, and the beautiful azure Pacific. Located between Mazatlan and Acapulco, Puerto Vallarta is the perfect vacation spot! There's all that ocean; for swimming, snorkeling, skiing, scuba diving, and fishing. Countless quaint shops, unique gifts, art galleries, scenic stops, and many points of interest. For romance, relaxation, excitement, good food, and good fun, join the tour for this wonderful holiday in Puerto Vallarta. The tour will leave Milwaukee February 23, returning March 1, 1980. It includes round trip air transportation, and seven nights accommodations at the luxurious Camino Real Hotel located on the beach.

You have all heard about the famous Passion Play in Oberammergau, Germany which is only presented once every ten years. Here's the perfect opportunity to witness this colorful pageant. The State Medical Society has arranged for two departure dates: August 28 to September 5, 1980 or September 4 to 12, 1980. Nestled in a high Alpine valley surrounded by towering peaks, Oberammergau provides a breathtaking setting for the Play. The village is picturesque, steeped in old world charm with woodcarvers; shops, hand-painted frescoes, and the dominant old church. This is an opportunity of a life-time dream, with a very special spiritual experience.

SMS members are urged to send in their reservations early to avoid disappointment. The savings are dramatic due to the low-cost chartered airline transportation, group land rates, service, and other included features. —**William P Crowley Jr, MD,** President—SMS Services, Inc

been in medical practice since 1928 in Wisconsin. He was one of the founders of the Green Bay Clinic and retired in 1975. He was a member of the Wisconsin Radiological Society and the Radiological Society of North America. Surviving are his widow, Roberta; two sons, Thomas J, Ashville, NC, and Dr Richard H of De Pere; and one daughter, Mrs Carolyn Atwood, Chapel Hill, NC.

Michael A Gertz, MD, 77, practicing physician and surgeon in the Ironwood area for 52 years, died Oct 1, 1979 in Hurley. Born March 15, 1902, Doctor Gertz graduated from Northwestern University Medical School in 1925. He began his medical practice in Ironwood in 1927.

◇ **Darrell S Sharp, MD**, 79, Hayward, died Oct 2, 1979 in Hayward. Born May 5, 1900 in Kossuth County, Iowa, he graduated from the University of Wisconsin Medical School in 1929. He served his internship at the Anchor Hospital in St Paul, and had practiced in Mondovi until his retirement in 1969. Surviving are his widow, Carol; a son, John, Richmond, Va, and a daughter, Sidney of San Francisco, Calif. ■

FETAL ALCOHOL SYNDROME

The negative effect of alcohol on the fetus has been suspected for centuries, but only within the last ten years has it been given public confirmation and a name: Fetal Alcohol Syndrome, commonly referred to as FAS. It can be mild *(eg,* lowered birthweight) or severe *(eg,* mental retardation), depending upon the amount and timing of maternal alcohol consumption, as well as other factors, including individual genetics.

In response, a state-sponsored FAS task force has been formed to spearhead a campaign warning women of the potential dangers alcohol can have on the unborn infant. The campaign will culminate the proclamation of January as "Fetal Alcohol Syndrome Awareness Month" by Governor Dreyfus.

During the campaign, physicians may expect an increased number of inquiries regarding FAS from patients. "Reference packets" on FAS for Health Professionals are available for $2.50 plus $1.15 for shipping and handling from the Wisconsin Clearinghouse for Alcohol and Other Drug Information, 1954 East Washington Ave, Madison, Wis 53704. These reference packets are available on loan through all medical libraries in Wisconsin. In addition, the State Medical Society of Wisconsin will provide "mini-brochures" free to doctors' offices (see below).

The State Medical Society is participating in the public awareness campaign and urges physicians to support it in any way possible—including speaking before community service groups on FAS. For more information contact Diane Upton at SMS offices in Madison: 608/257-6781 or toll-free 1-800-362-9080.

A brochure, "Alcohol and Your Unborn Baby" (in English and Spanish versions), published by the State Medical Society of Wisconsin for physicians and patients now is available in quanity by writing to:

The Communications Department
State Medical Society of Wisconsin
P. O. Box 1109
Madison, Wisconsin 53701

Prepared and distributed by the State Medical Society of Wisconsin

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

James F Mayr, MD,* Milwaukee, recently joined the Northwestern Mutual Life Insurance Company of Milwaukee as assistant medical director in the Underwriting Department. A 1971 graduate from the Medical College of Wisconsin, Doctor Mayr served as a lieutenant commander in the Navy since 1972 and came to Northwestern from a position as director of occupational health at the Portsmouth Naval Shipyard, New Hampshire.

O Mark Schneider, MD,* Blair, recently was named "Physician of the Year" by the Wisconsin Association of Nursing Homes. Doctor Schneider built the Blair Clinic and has practiced there for 30 years. He is the third Wisconsin physician to receive the award and was nominated by the Grand View Home of Blair and the Golden Age Home of Whitehall.

Elizabeth Tonn, MD and **Anne E Griffiths, MD,** Whitewater, recently opened their practice of family medicine as the Whitewater Family Practice Clinic. Doctors Tonn and Griffiths completed their residency in family practice at the University of Wisconsin, Madison, and both are affiliated with the National Health Service Corps. Doctor Tonn is a graduate from the University of Wisconsin Medical School and Doctor Griffiths graduated from the University of Michigan Medical School.

Robert Vickerman, MD, obstetrician and gynecologist, recently joined the medical staff of The Monroe Clinic. He graduated from the University of Iowa Medical School in 1967 and served in the United States Navy for 10 years. Prior to joining the Clinic, Doctor Vickerman had been in practice in the Groton-New London area.

William Carskadon, MD, LaCrosse, recently was technical adviser to a group of Wisconsin educators reviewing poison prevention materials designed by the Consumer Safety Product Commission. Doctor Carskadon is chief of the Department of Emergency Services at St Francis Medical Center, and is medical director of the LaCrosse Area Poison Center.

Joseph L Ousley, MD,* Marshfield, recently was appointed to serve on the Citizen Advisory Council at the University of Wisconsin—Eau Claire. He has been chief of the medical staff at St Joseph's Hospital, chairman of medical oncology, and a member of the executive committee of the Marshfield Clinic.

Mel S Blumenthal, MD,* Monroe, recently was elected to the board of directors of the First National Bank of Monroe. Doctor Blumenthal is a member of the Monroe Clinic and also is a member of the medical staff of St Clare Hospital. A member of Green County Medical Society, Doctor Blumenthal is a delegate to the State Medical Society of Wisconsin and also serves on the Committee on Environmental Health of the Commission on Governmental Affairs.

MDs John Allen, David Aughenbaugh,* Richard O'Connor,* and **Tom Starkey,*** of the Wausau Medical Center, recently attended the annual meeting of the American Medical Group Association in Las Vegas. Among the workshops attended were dealing in cost containment, occupational medicine, physician productivity, and managing conflicts of change.

John O Chamberlain, MD,* Milwaukee, recently was appointed to the Medical College of Wisconsin Board of Directors by Governor Dreyfus. A 1952 alumnus of the Medical College, Doctor Chamberlain is chief of staff at Columbia Hospital and assistant clinical professor of medicine at MCW. Doctor Chamberlain maintains a private practice in Milwaukee. He is past president of the Marquette-MCW Medical Alumni Association and is currently chairman of the Chief of Hospitals Medical Staff Committee of the Medical Society of Milwaukee County. ■

Toll-Free WATS line for members: 1-800-362-9080

As a service to its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference!

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc has appointed Jerome Coquillard executive director, according to an announcement by Kenneth Johnson, MD, president of the foundation's board of directors. For the past five years, Coquillard was associate director of the Health Insurance Association of America, Chicago, a national association representing more than 300 member companies.

Ron Andrews, Mt Horeb, has been named director of Sports Medicine Rehabilitation at Outpatient Rehabilitation Services in Madison. ORS opened in August 1978 to serve the special needs of physical therapy outpatients in Dane County.

Vicki Graziano, Middleton, has been named to the Physical Therapy Council of the State Medical Examining Board. The Council is responsible for examining and licensing graduating physical therapists. Mrs Graziano is Patient Care Coordinator and a physical therapist at Outpatient Rehabilitation Services in Madison. She also teaches with the School of Family Practice Medicine at the University of Wisconsin-Madison, serves as president of the Wisconsin Health Professionals, and is on the Board of Directors for the Wisconsin Arthritis Foundation. ■

Scoliosis programs in Wisconsin

THE BUREAU FOR CHILDREN WITH PHYSICAL NEEDS (BCPN) of the Wisconsin Department of Public Instruction recently distributed a revised edition of the handbook "Slow Dangerous Curve" and a copy of the October edition of the BCPN report which includes a report of the 1978-79 screening activities.

Horace K Tenney, MD, director of the BCPN, reported the following information:

"The target population for the scoliosis program is girls in grades 6-7-8-9 and boys in grades 8-9. The total state enrollment for these groups last year was 250,178 and if our figures are correct, 130,000 or slightly more than one-half were screened.

"The program as it now operates does not allow a calculation of the incidence of scoliosis since many of the children found to have a suspicious-looking back are taken directly to a physician and we do not learn of the outcome. However, for the 1701 who attended a clinic organized by the BCPN, 717 had a diagnosis of scoliosis and 85 of these children had a curve measuring more than 20°. Because of this we feel the program is useful.

"In order to reduce the amount of radiation received by children in this program, we are suggesting the following guidelines be used by physicians treating the patients.

A. Curves of 6° to 10° need not be followed more than annually.

B. Curves of 11° or more in a growing child should be followed at 6-month intervals unless progression of the curve has already been documented, in which case more frequent examinations may be indicated.

C. Followup examination including a single upright standing view will suffice (full spine). Recent work by Dr Clyde Nash[1] has demonstrated that the major organs at risk in scoliosis films are the breasts. The PA radiograph results in 60% less breast radiation than the standard AP. Adequate gonadal shielding should still be used.

D. Bending x-rays are only required for preoperative assessment and are not needed for diagnosis."

[1]Paper presented at 13th annual meeting of Scoliosis Research Society, September 1978—"Risks of x-ray radiation in patients undergoing long-term treatment for scoliosis."

Requests for copies of the above publications, or comments or suggestions concerning the scoliosis program or report, should be directed to: Horace K Tenney, MD, Director, Bureau for Children with Physical Needs, Division for Handicapped Children, Wisconsin Department of Public Instruction, 126 Langdon St, Madison, Wis 53702.

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Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, write John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 8tfn/79

WANTED: GENERAL SURGEON, board certified or eligible to join seven-man family practice group in a university town with trade area population of 22,000, 30 miles southeast of St Paul, Minn. JCAH approved hospital. Contact Roland M Hammer, MD, River Falls Medical Clinic, Ltd, River Falls, Wis 54022, or call collect 715/425-6701. 12tfn/79

GENERAL SURGERY—WE represent clients with the following immediate needs for surgeons: 1) a small college town with a population service area of 32,000, located in southwestern Wisconsin desires a general surgeon with some interest in orthopedic surgery; 2) a 190 bed hospital located in the tourist and recreational area of Michigan's Upper Peninsula seeks a general surgeon to provide care to a city of 17,000 and a service area of 50,000, and 3) a 21 member group located in the Fox River Valley area of northeastern Wisconsin wishes to add a third general surgeon to its clinic. Each client offers financial guarantees along with other fringe benefits and incentives. If interested, contact our executive search consultant, Jerry Gasser, Fox Hill Associates, Ltd, W156 N8327 Pilgrim Rd, Menomonee Falls, Wis 53051 or call collect 414/255-6500. 12/79

MULTISPECIALTY GROUP OF 32 physicians offering practice opportunity to:

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Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

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ANESTHESIOLOGIST AVAILABLE for relocation. Mid-40s, Board certified, Wisconsin license. Will consider smaller cities. Write Dept 474 in care of the Journal. p11-12,1/80

Physicians Exchange

continued

WANTED: FAMILY PRACTICE physician to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

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- Pediatrics
- Nephrology
- Dermatology
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Modern, state of the art facilities, adjacent to Theda Clark Regional Medical Center and another building located on the Fox River. First-year salary open; full membership after one year. Liberal benefits including qualified Profit-Sharing Plan, and emphasis upon continued education. Outstanding professional and personal life-style opportunities. Excellent recreational area, located on the north end of Lake Winnebago. For more information, send letter and resume in confidence to E E Wilson, MD, Chairman, Recruiting Committee, or D J Anderson, FACMGA, Admin, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956, or call 414/725-7071. 12/79,1-5/80

WANTED: OB/GYN BOARD certified or eligible-Immediate Opening; Internist-Board Certified or eligible-July 1980 to join four internists, two pediatricians, Ob-Gyn and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first-year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact J L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53072. Tel: 414/673-5745 (collect) 12tfn/79

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ORTHOPEDIC SURGEON—urologist—ENT—gynecologist needed for a primary-care group of ten physicians, one internist, one surgeon in northwestern Wisconsin. Contact L R Cotts, MD, 715/234-9031, 1020 Lakeshore Dr, Rice Lake, Wis 54868. 12/79,1-2/80

WANTED: DIAGNOSTIC RADIologist to join two-man service corporation covering 185-bed hospital and 32-physician clinic. Consideration for early partnership. Contact Jacob M Gerend, MD, 705 Oak Tree Rd, Sheboygan, Wis 53081. Tel: 414/458-0050.12/79,1-5/80

WANTED: GENERAL SURGEON to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

RACINE MEDICAL CLINIC, SC, multispecialty group of 18 physicians has a practice association for

- Internist
- Obstetrician-Gynecologist
- Family/General Practitioner

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 7tfn/79

WANTED: GENERAL PRACTItioner to join well established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Rose-Jensen-Manabat, 621 E Walnut St, Green Bay, Wis 54301. Tel: 414/437-4366. 10-12/79

BOARD CERTIFIED OR ELIGIble primary care internists and family practitioners wanted for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel:414/289-5910. 9-12/79

WANTED: ORTHOPEDIC SURgeon to practice with one other orthopedic surgeon, multispecialty clinic, primary care oriented with 13 MDs. New hospital immediately adjacent to clinic. 65 miles from Minneapolis/St Paul on I-94. Ideal situation for family-oriented lifestyle. Recreation, time off, congenial group. Rapidly growing college community. No seniority and full status after one year. Competitive salary first year. Contact Rex Shaffer, Manager, or Dr James Haemmerle. Call collect 715/235-9671, or write Red Cedar Clinic, 2211 Stout Road, Menomonie, Wis 54751. 7-12/79

GREEN BAY, WISCONSIN—AN excellent opportunity is available for a family practice physician in the Green Bay, Wisconsin area. A younger family practice resident, or general practitioner with some experience is desired. New office setting is in close proximity of a family practice oriented hospital facility. Association and practice arrangements flexible. Contact: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. p11-12/79

FAMILY PRACTITIONER wanted for rural area in NW Wisconsin, town of 2500, service area includes 25,000 patients. Joint four ABFP and one Board certified surgeon in a growing family oriented group practice. Excellent salary and benefits. New large clinic building ready for occupancy June 1, 1980, close to JCAH approved hospital. The service area is one of the most desirable living areas in Wisconsin with unlimited outdoor recreation available. Contact: Paul G Goellner, MD, Spooner Clinic Ltd, Spooner, Wis 54801. Tel: 715/635-2151. 10-12/79, 1/80

FAMILY PRACTICE — SOUTHeast. Private practice opportunity group or solo in medium-size city with new 150-bed hospital. Present medical staff of 24 with three FPs age 64. Attractive office space and complete financial assistance package. Family oriented stable community. Curriculum vitae in confidence to: Mr William Anderson, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Ga 30338. p10-12/79

GENERAL INTERNIST WITH GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info: J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

RADIOLOGIST WANTED: IMmediate vacancy in Door County to join radiologist in solo practice. Recreation at your doorstep. Contact: R G Evenson, MD, 535 South 8th, Sturgeon Bay, Wis 54235. Tel: 414/743-8667. 2tfn/79

NEUROLOGIST WANTED — Clinical Neurologist wanted to practice in conjunction with a 6-member Internal Medicine Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 470 in care of the Journal. 9tfn/79

OB-GYN WANTED — TO PRACtice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

PEDIATRICIAN TO JOIN 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

THE MIDELFORT CLINIC IS seeking associates in the following areas:

- Family Practice
- Cardiology
- Allergy

This is an opportunity to affiliate with a 48 member group located in a college community of 50,000. Satellite practice locations also available. Contact G E Owen, MD, Midelfort Clinic, Ltd, Eau Claire, Wis 54701 or call 715/839-5222. 10-12/79

TWO FAMILY PRACTICE PHYSIcians to join or associate with multispecialty group in satellite setting in semi-rural community 30 miles north of Milwaukee in beautiful Kettle Moraine. Financial arrangements, benefits, and practice opportunity exceptional. Contact Executive Director, Hartford Memorial Hospital Foundation. Tel: 414/673-2300 (collect) 11-12/79,1/79

GROUP HEALTH COOPERAtive of south Central Wisconsin. A growing federally qualified staff model HMO—is recruiting family practitioners for January 1980. Excellent salary, pension and benefit program in an area of natural beauty make living and working here very attractive. Write or call David S Grab, MD, Medical Director, 1 South Park St, Madison, Wis. Phone 608/257-9700. An Equal Opportunity Employer. 7-12/79

FIFTY-MAN MULTISPECIALTY group has an immediate opening for:

- Orthopedic Surgeon
- Ophthalmologist
- Family Practice
- Psychiatrist

Excellent starting salaries with all fringe benefits. Monroe is a very stable economically-strong community of 10,000 located 45 minutes from Madison and 90 minutes from Milwaukee. If interested, please contact T E Peters, MD, The Monroe Clinic, Monroe, Wis 53566. 9-12/79, 1-2/80

FAMILY PRACTITIONER TO join three man group. Central Wisconsin community of 10,000 with drawing area of 20,000. Hundred bed accredited hospital. Handsome salary first year with many fringe benefits, full partnership second year. Send curriculum vitae to Merrill Medical Associates, SC, 716 East Second St, Merrill, Wis 54452. Tel: 715/536-2463. 10-12/79

GONZALEZ MEDICAL CENTER is seeking a pediatrician who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, telephone 414/344-1120; 414/671-5410; 414/476-8624. 8-12/79, 1/80

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency

9tfn/79

NEUROLOGISTS: BOARD ELIgible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG. Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

FAMILY PRACTICE—IMMEDIate opening. Two diplomates seek third family practitioner to join them in Janesville, Wis. Salary negotiable. Excellent benefits, unparalleled opportunity. Respond Palmer Green Medical Associates, 2000 E Racine St, Janesville, Wis 53545. 608/752-7803 earliest convenience. p12/79

FAMILY PRACTICE AVAILABLE for one or two physicians. Thirty-year established practice of deceased physician. Excellent accredited hospital facilities located in Menomonee Falls, Wisconsin and only 10 miles from Milwaukee County Medical Complex. Area offers good schools and recreational facilities for family. Write to PO Box 307, Menomonee Falls, Wis 53051, or phone 414/251-5655. g12tfn/79

Allied Health Services

WISCONSIN OPTOMETRIST, highly experienced in all phases of contact lens fitting desires position in ophthalmologist's office or hospital. Have fitted for ophthalmologists for over 20 years. Can give excellent references. Contact Dept 475 in care of the Journal. p12/79

FAMILY PHYSICIAN OR General Practitioner. Excellent opportunity for the new physician desiring a good start or the experienced physician wanting a change. Progressive community located 30 miles east of Green Bay is seeking another physician to join the Algoma Clinic. Service area of over 6,000 presently served by four very active, cooperative, talented physicians. Good hospital (JCAH) approved in town. Generous starting income guaranteed with tremendous future and income potential. Full partnership after one year if desired. Rural living with small town privacy yet close to bigger cities of Green Bay and Milwaukee. Excellent recreational area for fishing, hunting, camping, boating, sailing, cross country and downhill skiing. Fine schools, library, churches, and social organizations. We would enjoy showing you and your family what we have to offer. For further details call collect or contact Steven H Spencer, Admin, Algoma Memorial Hospital, Algoma, Wis 54201. Tel: 414/487-5511. 12/79*

Medical Facilities

SPACE AVAILABLE IN WESTwood professional building, Delafield, Wis. 2000 sq ft on ground level; design your own floor plan. Easy access to I-94. Oconomowoc Memorial is just 10 minutes away. Negotiable lease. Call 414/276-0431 or 414/646-2340. 11tfn/79

PROSPECT BUILDING. SEVERAL medical suites now available, including custom plumbing and examining rooms. Utilities and janitorial service included in base rental of $6.50 per square foot. Undercover parking for tenants and visitors. Ideally located at North and Prospect, Milwaukee. Call 414/278-7511. p11-12/79

FOND DU LAC FACILITY. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

GREEN BAY, WISCONSIN NEW prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Recreational

FOR RENT: CARIBBEAN PARadise furnished two bedroom apartment near golf, private pool, beach, tennis, twenty minutes from St Thomas $300.00/week. Write: Joseph E Binard, MD, Naval Hospital, Roos Roads, Puerto Rico, FPO, Miami, Florida 34051. p12/79,1-2/80

Publications

Feeding Infants. A nutrition monograph for health professionals. As a result of numerous requests about and interest in the area of infant feeding, the public health nutrition staff of the Wisconsin Division of Health devoted all of the 1977 "Nutrition Newsletter for Nurses in Community Health Services" to current recommended practices in infant nutrition. This monograph is a compilation of the newsletters. Some of the topics presented are controversial and subject to individual interpretation. Nutrition research is dynamic, thus, there is not always one correct answer. The information which follows is current and supported by reliable references. It is hoped this monograph will be of assistance in your education and counseling efforts. The preparation of the newsletters and this ensuing monograph represent the combined effort and expertise of the public health nutrition staff with editing and review by the Maternal and Child Health Section of the Wisconsin Division of Health. Major contributions in reviewing research and clinical practice as well as in drafting the manuscript have been made by Wisconsin Division of Health Public Health Nutritionists: Scherle Barth, RD, MS; Betty Griffin, RD, MPH; Laurie Norstedt, RD, MS; Linda Peterson, RD, MPH; Mary Jo Tuckwell, RD, MPH; Terry Williams, RD, MPH; and Elizabeth Spencer, RD, MS (North Central Perinatal Center). The monograph has been reviewed and endorsed by the Wisconsin Chapter of the American Academy of Pediatrics. The 54-page, 8 1/2 x 11 inch publication is available free in Wisconsin (in single or small quantity) upon request to: Bureau of Community Health Services, State Division of Health, PO Box 309, Madison, Wis 53701; or phone 608/266-2661. (Available outside of Wisconsin for $1.25, including postage and handling, either singly or in bulk.)

Directory: Aviation Medical Examiners, February 1979. Published by US Dept of Transportation, Federal Aviation Administration, Office of Aviation Medicine. This directory contains the names and addresses of physicians who are authorized to perform physical examinations and issue airman medical certificates for the Administrator of the Federal Aviation Administration. All Examiners listed are authorized to conduct airman physical examinations for Second Class and Third Class Medical Certificates. They are also authorized to issue the combination Medical—Student Pilot Certificate. Physicians interested in becoming Aviation Medical Examiners should request application forms from the FAA Regional Flight Surgeon. In Wisconsin that would be the GREAT LAKES REGION. Address: Paul L Brattain, MD, FAA, Federal Building, 2300 East Devon, Des Plaines, Ill 60018. AC 312/694-4500, ext 491. There are 144 Wisconsin physicians listed in the directory. A copy of the directory is in the WMJ Library.

Marijuana and Heroin by Prescription? Recent developments at the state and federal levels. A reprint from *JAMA*, Jan 26, 1979 which is available at no charge from: Food and Drug Administration, Education & Professional Training, 5600 Fishers Lane, HFY-4, Rockville, Maryland 20857.

How Laetrile Laws Affect MDs. A reprint from *Legal Aspects of Medical Practice*, October 1978. Available at no charge from: Food and Drug Administration, Education & Professional Training, 5600 Fishers Lane, HFY-4, Rockville, Maryland 20857.

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Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1978 through Aug 31, 1979.

1980 Wisconsin

Jan 3-9: 13th Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics and Endocrinology,* at Pfister Hotel and Tower in Milwaukee. Six-day course extended to include a complete up-to-date review of endocrinology and cytogenetics in addition to a thorough resume of gynecological pathology. Designed primarily as a postgraduate refresher course for residents, practitioners, and specialists desiring a current review of the pathology and the reproductive tract. Guest faculty: H W Jones, MD; Georgeanna S Jones, MD; J D Woodruff, MD; and Conrad Julian, MD. Space limitation requires registration for the entire course which is limited to 150 registrants. Approved for 55 cognate hours of prescribed credit by ACOG and meets criteria for 43 hours of credit in Category 1 for the PRA-AMA. A $450 enrollment fee will include 68 selected 35mm slides. Registration fee is nonrefundable. Info: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, Medical College of Wisconsin, 8700 West Wisconsin Ave. Milwaukee, Wis 53226; phone 414/257-8200.

Jan 10: *DSM III: A Workshop With the Architects,* Wisconsin Center, Madison. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706. (Further details elsewhere in this section)

Jan 16-18: *10th Annual Winter Refresher Course for Family Physicians.* The Pfister Hotel and Tower, Milwaukee. Info: Mrs Susanna Rechlitz, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, WI 53211. Tel: 414/291-0813.

Jan 16: *Geriatric Medicine.* St Mary's Hospital Medical Center, 707 South Mills St, Madison. Approved 4 hours prescribed credit AAFP and Category 1 PRA-AMA.

Feb 12-14: Telemark Symposium and Ski Outing, Mt Telemark, Cable, Wis, sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians. Faculty from the Mayo Clinic. Six hours AAFP and AMA Category I credit. All physicians invited. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

Feb 18: *Great Lakes Ski-In: Survival in Emergency Medicine.* Playboy Club, Lake Geneva. Info: J Gennrich, MD, Wisconsin ACEP, 10201 W Lincoln Ave, Milwaukee 53227. Tel: 414/545-5568

Feb 21: *A Day of Cardiology.* Methodist Hospital, 309 W Washington Ave, Madison. Approved 4 hours prescribed credit AAFP and Category I PRA-AMA.

Mar 1-8: 15th Annual Clinical Conference, sponsored by the Medical College of Wisconsin and the Marquette-MCW Medical Alumni Association, Wailea Beach Hotel, Maui, Hawaii. Info: Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226 (414/257-8204).

Mar 12: *A Day of Cancer, Prevention and Therapy.* UW Center for Health Sciences, 600 N Highland Ave, Madison. Approved 4½ hours prescribed credit AAFP and Category 1 PRA-AMA.

Apr 17-18: *Third Annual St Mary's Symposium on Burns and Critical Care.* Presented by St Mary's Hospital Burn Center, Milwaukee. Format: Combination of didactic lectures and workshops, separate and combined sessions for nurses and physicians. Co-chairmen: Burton A Waisbren, MD and George E Collentine, MD. Info: St Mary's Burn Symposium, 2323 N Lake Drive, Milwaukee, Wis 53211.

May 17-18: Workshop on Practice Management, Red Carpet Inn, Milwaukee. 11½ hours AAFP and AMA Category I credit. Info: AAFP, 1740 West 92nd St, Kansas City, MO 64114.

June 26-28: Wisconsin Academy of Family Physicians Annual Scientific Assembly and Congress of Delegates, Chula Vista Resort, Wisconsin Dells, Wis. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

Current issues in medicine

A Health Science Telephone Conference for physicians

Sponsored by State Medical Society of Wisconsin, Commission on Continuing Medical Education, and University of Wisconsin-Extension, Dept of CME

Eight programs, five remaining in 1980—

January 16—*Health Systems Plans and the State Health Plan Process*

February 13—*What Cost Containment, Rate Review, and Physician Fee Regulations Mean to Physicians*

March 19—*Antitrust, and the Federal Trade Commission*

April 16—*Legislative Wrap-up 1979-80*

May 14—*State Regulations: The Administrative Rule Process*

For more information call: **Bill Wendle,** Health Services Division, SMS of Wisconsin (608) 257-6781 or toll-free 1-800-362-9080.

1980 Others

Mar 9-15: American Society of Contemporary Ophthalmology, joint meeting with international Glaucoma Congress, Sheraton Twin Towers, Orlando, Florida. Up to 50 CME hours, Category 1. Info: John Bellows, MD, ASCO, 6 North Michigan, Room 1110, Chicago, Ill 60602.
12/79,1-2/80

NUCLEAR CARDIOLOGY for the PRACTICING PHYSICIAN

Third Annual Symposium arranged by Dr Harold L Brooks and Dr Jagmeet S Soin at the Medical College of Wisconsin

July 27—July 30, 1980

The Hilton Head Inn at Sea Pines Plantation, Hilton Head Island, South Carolina

Course is designed to bring the state of the art in Nuclear Cardiology to the practicing physician in community hospitals throughout the nation, specifically to physicians specializing in nuclear medicine, cardiology, and residents, fellows, and technologists. Program will consist of lectures, detailed panel discussions with audience participation and on-site demonstrations of current equipment.

For information contact—

Dr Jagmeet S Soin, Division of Nuclear Medicine, Milwaukee County Medical Complex, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

CONVENTIONAL AND CONTEMPORARY THERAPY

Pain—Atherosclerosis—Allergy—Cancer

February 8 & 9, 1980

Holiday Inn Illinois State Beach Park, Zion, Illinois

Two day CME conference sponsored by Biogenic Institutes of America, Inc, The Pain and Health Rehabilitation Center and American International Hospital and Clinic

Lectures and workshops by national authorities on the important subjects listed above.

Info: Pain and Health Rehabilitation Center, Route 2, Welsh Coulee, LaCrosse, Wis 54601.
Tel: 608/786-0611 12/79

Mar 9-15: American Society of Contemporary Medicine and Surgery, 15th annual meeting. Sheraton Twin Towers, Orlando, Florida. Up to 40 CME hours, Category 1; acceptable for 25 prescribed hours, AAFP. Info: John Bellows, MD, ASCMS, 6 North Michigan, Room 1110, Chicago, Ill 60602. 12/79,1-2/80

1980 AMA

Jan 12-15: AMA Winter Scientific Meeting in San Antonio, Texas. Postgraduate courses, symposia, exhibits, and other events will be presented.

Mar 13-15: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Phoenix, Ariz. See details elsewhere in this section.

DSM III: A WORKSHOP WITH THE ARCHITECTS

January 10, 1980

Wisconsin Center, Madison, Wisconsin

Audience: Psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, medical records personnel and other health care personnel who will be using manual.

Fee: $60.00

Subject: Introduction to the *Diagnostic and Statistical Manual III* which will be the standard psychiatric classification in the US on January 1, 1980.

Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706

GREAT LAKES SKI-IN: SURVIVAL IN EMERGENCY MEDICINE

A course on Management, Legal and Financial Aspects of EM and EMS Impact

Playboy Club, Lake Geneva, Wis
February 18, 1980

Sponsored by Wisconsin Chapter, American College of Emergency Physicians

8 hours Category I credit of ACEP/AMA and AAFP. Fee: $85-$100.

Info: J Gennrich, MD, Wisconsin ACEP, 10201 W Lincoln Ave, Milwaukee, Wis 53227. Tel: 414/545-5568.

Apr 17-18: AMA 33rd National Conference on Rural Health, Boston, Mass. See details elsewhere in this section.

Apr 18-19: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Cherry Hill, New Jersey. See details elsewhere in this section.

June 12-14: *AMA Seminar on Knowledge and Skill Development in Negotiations.* Burlingame, Calif. See details elsewhere in this section.

Sep 12-13: *AMA Seminar on Knowledge and Skill Development in Negotiations.* Kansas City, Mo. See details elsewhere in this section.

AMA Department of Negotiations presents

SEMINARS ON KNOWLEDGE AND SKILL DEVELOPMENT IN NEGOTIATIONS

March 13-15,1980

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution.* Hyatt Regency Hotel.
Phoenix, Arizona

April 18-19, 1980

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution for Hospital, HMO, Academic and Other Salaried Physicians.* Cherry Hill Holiday Inn.
Cherry Hill, New Jersey

September 12-13, 1980

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution with Health Planning and Other Government Agencies.* Radisson-Muehlebach Hotel.
Kansas City, Missouri

June 12-14, 1980

Advanced seminar for physician negotiators: *Dynamics of Conflict Resolution.* Burlingame Hyatt House.
Burlingame, California
(near San Francisco International Airport)

As an organization accredited for continuing medical education, the AMA Council on Continuing Physician Education certifies that the continuing medical education activities designated Category I meet the criteria for Category I on an hour-for-hour basis for the Physician's Recognition Award of the American Medical Association.

For more information on above educational programs, contact AMA Department of Negotiations, 535 North Dearborn St, Chicago, Illinois 60610, or call 312/751-6652.

33rd National Conference on Rural Health

Boston, Mass/Sheraton Boston
April 17-18, 1980

Sponsored by AMA in cooperation with AHA, ANA, APhA and others

Seven continuing medical education courses placing particular emphasis on the needs of the rural practitioner. CME courses meet the criteria for Category I accreditation on an hour-for-hour basis for the Physician Recognition Award of the AMA.

Courses:

- *Common Poisoning Emergencies.* Instructor: Frederick H Lovejoy, MD, Children's Hospital Medical Center, Boston, Mass.
- *Sportsmedicine in Rural Schools.* Instructor: J M Ingalls, MD, Paris Community Hospital, Paris, Ill.
- *Plastic Wound Closure Techniques for the Primary Care Physician.* Instructor: William M Champion, MD, Plastic Surgery Associates, Inc, Seattle, Wash.
- *Nutritional Assessment and Management in Rural Areas.* Instructor: George Blackburn, MD, New England Deaconess Hospital, Boston, Mass.
- *Agricultural Health Problems.* Instructor: Kelley J Donham, DVM, Institute of Agricultural Medicine, Department of Preventive Medicine and Environmental Health, University of Iowa College of Medicine, Iowa City, Iowa.
- *Primary Management of Severe Head Trauma.* Instructor: David G Piepgras, MD, Department of Neurologic Surgery, Mayo Clinic, Rochester, Minn.
- *Hand Amputation: How to Help a Patient and Microsurgeon.* Instructor: Allen Van Beek, MD, Division of Plastic Surgery, Section of Microsurgery, Southern Illinois University School of Medicine, Springfield, Ill.

Physicians wishing further information about the course schedule should call Mrs Barbara Chapman (312/751-6604 or 312/787-6695) or Mr Dale C Smith (312/751-5997 or 312/525-1280), or write to the Department of Community Health Systems, AMA, 535 North Dearborn St, Chicago, Ill 60610.

Christmas is a time of giving

■ "Christmas is a time of giving"—words expressed so beautifully in Joan Walsh Anglund's small book. Not only at Christmas but all year physicians have given to AMA-ERF. I want to report at this holiday season just how much physicians' financial support has meant to medical education in Wisconsin. ■ In May checks were presented to Dean Harold Brown of the University of Wisconsin Medical School for $11,898 and to Dean Edward Lennon of the Medical College of Wisconsin for $14,106.43. The 1978-1979 Final Report of AMA-ERF contributions from Wisconsin shows that the SMS Auxiliary earned $16,977.78 and Wisconsin physicians contributed $8,286.00 for a grand total of $25,263.78. ■ AMA-ERF is engaged principally in supporting medical education; providing financial assistance to medical students, interns and residents; fostering scientific and medical research; and providing funds for rural and community oriented pilot health projects. ■ The Foundation's Loan Guarantee program was established in 1962. Since that date almost $90 million in loans have been guaranteed through AMA-ERF. In 1978 the Foundation guaranteed $5.8 million in loans to more than 4000 students and physicians in training through its loan guarantee program. There has been such an increase in demand for student loans that each medical school in the nation has been limited to 50 loans per year. A student may borrow $2500 annually, up to a limit of $12,500 over a seven-year period. ■ There were 41 loans granted in Wisconsin last year. Six of these loans were used by interns. Four student loans were used at the UW Medical School and 37 were given at the MCW. Physicians' children are eligible to borrow from these funds. ■ Of all the many worthy causes to which physicians could contribute this holiday season, few can match AMA-ERF in providing such lasting and important benefits. **Please remember that a donation is tax-deductible.** And physicians, through a gift, can make a significant contribution in helping AMA-ERF achieve its primary goal—continued progress and excellence in medical education and research. ■ Please complete the form below and mail it with a check (payable to AMA-ERF "Auxiliary Fund").

AMA-ERF

TO: Mrs Leslie H Stone
AMA-ERF State Chairman
SMS Auxiliary
1835 Lake Breeze Road
Oshkosh, Wisconsin 54901

Enclosed is my check for $ _____

☐ _____ Medical School

☐ _____ Loan Guarantee Program

Signed _____

Address _____

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

COURT AGREES WITH MEDICAL SOCIETY BRIEF. In a recent ruling, the Court of Appeals upheld the concept of professional service corporations in Wisconsin. In its decision in *Melby v O'Melia,* the court ruled that withdrawal of a shareholder from a professional corporation does not mandate the dissolution of a professional corporation. Furthermore, when a professional corporation is dissolved, corporate rather than partnership law governs the dissolution. The court heard an appeal on whether, under any circumstances, a statute must give way to professional ethics. While the court withheld a decision in this appeal, in doing so, it in effect affirmed the lower court decision and disregarded the issue. The State Medical Society filed an amicus curiae brief on these issues outlining the Society's feeling that the proposals were nonsensical and would do incalculable damage to medical and other professional practices. (Copies of the *Guide to the Service Corporation Law* are available upon request to the SMS Communications Dept)

CHIROPRACTIC CARE ADVICE. Attorney General Bronson LaFollette last week issued the following opinion: "The Medical Practice Act, ch 448, Stats, permits a physician, subject to certain limitations, to advise a patient whether or not continued chiropractic care is necessary, and the giving of such advice while it may technically fall within the definition of chiropractic practice does not constitute the unauthorized practice of chiropractic." LaFollette issued the opinion following a request by the Chiropractic Examining Board. "In giving advice to patients, there is an overlap between what may properly be done by a chiropractor and a physician under their respective grants of statutory authority," LaFollette said. "In my view, a physician is given the latitude to perform services within his or her authority, whether those services overlap with professional services performed by a chiropractor, or other health care professional. To find otherwise would be to place unreasonable restraints on the practice of medicine," he said.

TITLE 19 PROGRAMS CONVERT TO CPT-4 AND ICD9-CM CODES. The Dept of Health and Social Services and EDS-Federal Corporation have announced their records have been converted to CPT-4 procedure and ICD9-CM diagnosis codes. Beginning with the first payment made after December 1, 1979, the remittance advice will show payment made in CPT-4 code and language. Physicians' offices are urged to begin using these coding references as soon as possible. It is anticipated that these coding systems will be mandated by early spring 1980. The 1978 SMS House of Delegates officially endorsed CPT-4 as the procedure coding system of choice. Copies of the CPT-4 and ICD9-CM guides are available as well as a mini-guide that converts the old Title 19 procedure codes to the new CPT-4 codes. Copies of the CPT-4 guide at a cost of $12.00 per copy may be ordered from: Order Dept, OP-41 AMA, PO Box 821, Monroe, Wisconsin 53566. The ICD9-CM guide may be ordered from the American Hospital Association, Attn: Order Dept, 840 North Lakeshore Drive, Chicago, Illinois 60611. The cost of the three-volume ICD9-CM set is $49.50, but any single volume can be purchased for $19.50. EDS-Federal recommends volume two as being most helpful for physicians. ■

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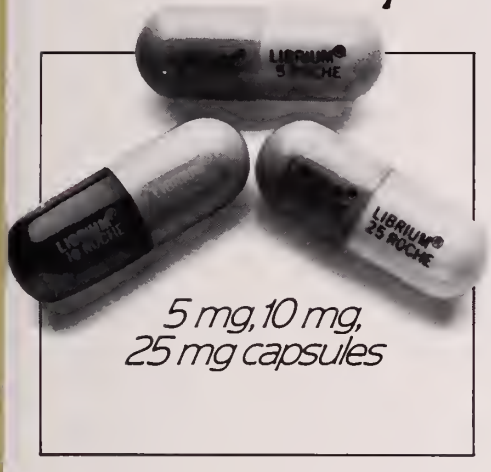

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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